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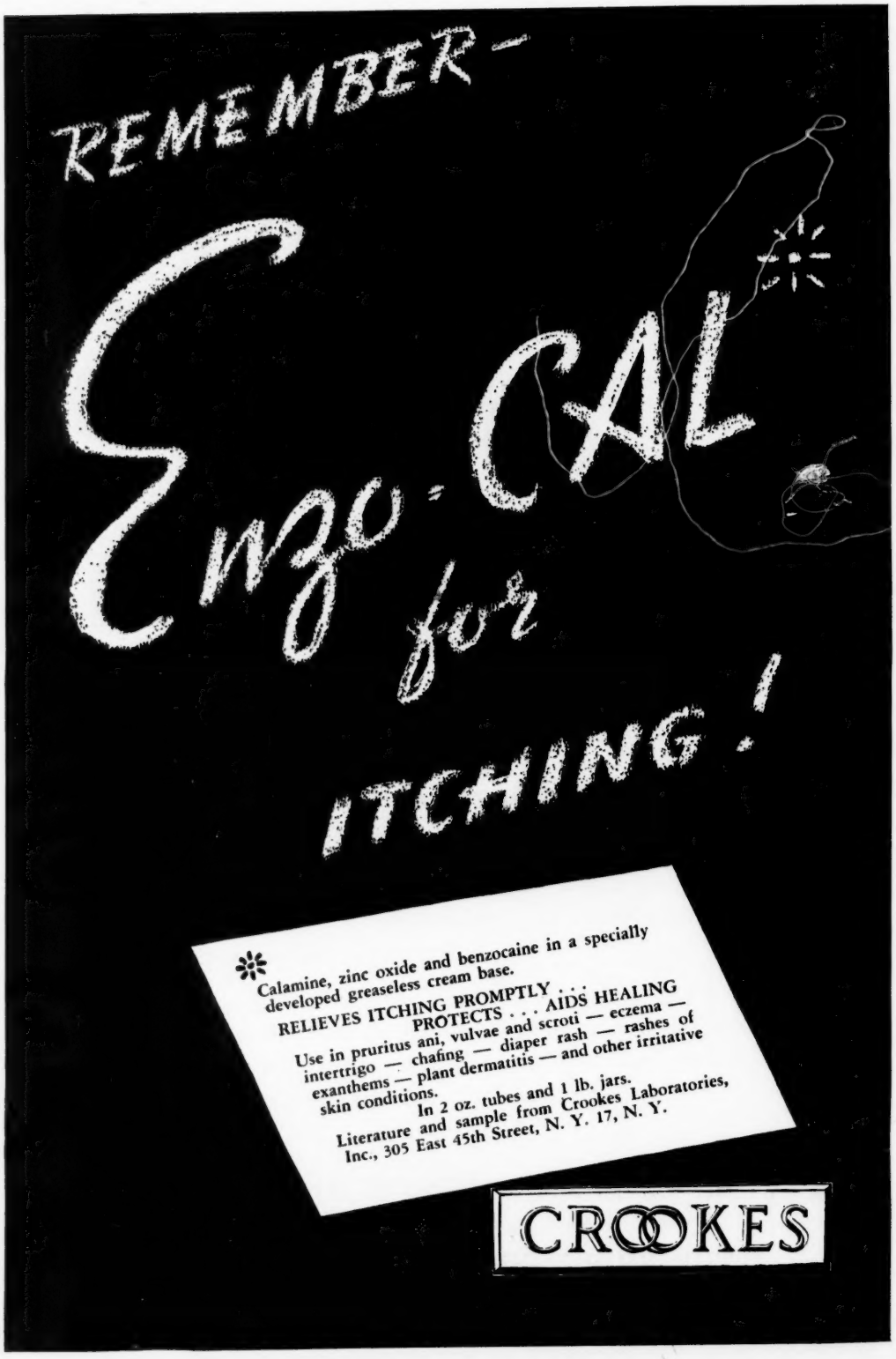
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The RHODE ISLAND MEDICAL JOURNAL

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THE DIAGNOSIS AND PRIMARY SURGICAL TREATMENT OF INJURIES OF THE HAND*

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Not less than seventy out of every one hundred industrial accidents result in injury of the hand. Ninety-eight out of every one hundred persons engaged in industry may become totally incapacitated because of one crippled hand. Stockroom, shipping-room workers, janitors, a small percentage of oilers, elevator operators, time clerks and watchmen, comprise the majority of those employed in industry who may, in some degree, earn a living with one crippled hand. Business men recognize the fact that disabling injuries hurt business, and have for some time past done a great deal in accident prevention work. Safety engineers employed by insurance companies, and inspectors from the Department of Labor and Industries of the several States, make routine examinations of industrial plants to assure the working man or woman a safe place in which to work. They have accomplished a great deal. There is, however, no real way of applying a fool-proof protective device on a circular saw which every year injures seriously the human hand. There seems to be no sure way of preventing a punch press from repeating with a person's hand caught in it when the press comes down. There is no rule anywhere in effect in industry which demands that one man alone shall clean and oil a machine. Very frequently while a man is engaged in such work, with the machine at rest, another man sets the machine in motion, and a wiping rag in the oiler's hand in an instant is drawn into the machine with the hand, wrist and forearm wound about a moving shaft. Flesh and bone alone stop the machine and forever that man has at best a partially crippled hand. Departments of Safety in each State and police departments recognize the value of loud speakers to direct traffic and warn persons of nearby danger. "Single file only on hill, slippery when wet", signs are seen on our highways. At the zoo the child who can read understands the meaning of the sign, "Do not put your hand inside the cage". Valuable, indeed, are the measures which have been taken in industry to protect the workingman's hand. Sufficient emphasis has not been laid on warning the workingman that *he* must protect his hand. At times a person is set back a little when a check is returned with the notice that the account is overdrawn. This predicament need not occur if one pays attention each month to the statement received from the bank. Too often a step broken for some time is repaired only after a person has fallen and fractured a hip. A worker gets in a rut about working at moving machinery—so does management, and something serious has to happen to jog one out of the rut. How worth while it would be in the machine shop, the carding room in the mill, or in the pattern shop, to have the loud speaker once a month warn the worker about safeguarding the hand. Three minutes a month would be sufficient time for it, and work could continue while the information is broadcasted.

If everything were done which could be done, and at present that is not so, the workingman would still injure one of the most useful parts of the body, —the human hand. When he does injure it, a doctor should be called. Matters of detail will not be discussed in this short address. Certain important "musts" will be considered.

Diagnosis of Injuries

Skin, underlying fatty tissue, muscles and tendons, bones, nerves and blood vessels, are the structures injured. The unbroken skin is highly resistant to infection. Once the skin is broken, all exposed underlying parts are in danger of infection. The time which elapses from the very instant the accident happens until a potentially infected wound is cleansed is the danger zone time, and

continued on next page

* Presented at the Fall meeting of the New England Conference of the American Association of Industrial Physicians and Surgeons, at Pawtucket, R. I., October 10, 1945.

much depends on what happens in that time. A lay person can make a diagnosis of skin injury when a cut in the skin is seen. It is very difficult, however, accurately to diagnose degrees of skin injury and to decide how much skin may not remain viable, and what to do about it as a part of primary treatment. How much skin should be excised? Should a skin graft be a part of the primary treatment? If skin graft is done, what type of skin graft should be used, and from what part of the body should the skin be removed? How much tension will a certain layer of skin stand after sutures have been taken? What is the significance of blanching of skin edges after suturing?

A diagnosis of muscle and tendon injury is not as a rule difficult. The joints in the hand are largely ginglymus or hinge joints, and permit chiefly of two motions,—flexion and extension. These motions are brought about, therefore, through flexor and extensor muscles with their tendon attachments. In a general way it is correct to say most all of the flexor and pronator muscles arise from the region of the inner side of the elbow; the extensors and supinators from the outer side of the region of the elbow; that is, a short distance below and above the elbow joint. All of the important long flexor muscles pass beneath the anterior carpal ligament through the carpal canal. This canal is in diameter the size of one's little finger; the roof of it, the anterior carpal ligament, and that is seldom deeper than one-half inch or, at the most, three-quarters of an inch beneath the surface of the skin. In this canal with these flexor tendons passes but one large nerve — the median nerve. If, therefore, you see a wound in the wrist, which is a half-inch or more in depth and frequently less than a half-inch in depth, you should at once be mindful of tendon and nerve injury. Proximal and distal flexion palmar creases, metacarpo-phalangeal creases and joints, proximal interphalangeal and distal interphalangeal joints are terms frequently used. As you look at the injured hand, remember that if the joint nearest the fingernail does not bend after trauma, a deep flexor tendon has been somewhere divided. If the joint nearest the palm of the hand does not flex following a hand injury, one or both halves of the superficial or short flexor have been injured. The metacarpo-phalangeal joints are quite complex. To simplify their action somewhat, and to facilitate diagnosis of injuries to structures which move these joints, these facts should be kept in mind.

There are four lumbrical muscles: the first two serve the index and mid-fingers, and the last two, the ring and little finger. There are seven interosseous muscles. In a general way these arise from the sides of the metacarpal bones. The palmar and the dorsal interossei have somewhat separate functions. The chief function of all these interossei muscles is to spread the fingers apart and to bring the fingers together.

Please look at your hand, with the palmar surface facing you and the fingers extended. Look at the metacarpo-phalangeal joints. Flex those joints to right angle position. That action is brought about by the combined action of the lumbricals and, to a certain extent, I believe, by the interossei. It is not difficult to understand these actions if you bear in mind the origin of the lumbrical muscles from the deep flexor tendons and their insertion in a general way on the extensor surface of the finger at the metacarpo-phalangeal joint. The interossei muscles, as has been stated, come from the sides of the metacarpal bones and are inserted, in a general way, on the extensor surface of the metacarpo-phalangeal joints. It is not error to consider the structure which extends the metacarpo-phalangeal joints and the interphalangeal joints as being made up of three structures fused into one. Certain anatomies differ in some detail from this interpretation of the distribution of these structures. The first two lumbrical muscles are supplied by the median nerve. The third and fourth by the ulnar nerve. All of the interossei are supplied by the ulnar nerve. If the workingman's hand after injury is incapable of carrying out these motions above described, then muscles with tendons or nerves have been injured.

The Thumb

Consider the thumb. Look at it with the palm of the hand facing you. Bend the distal joint of the thumb, the only interphalangeal joint in it. That action is brought about through the long flexor. Place your finger on the skin at the middle of the wrist joint with the interphalangeal joint of the thumb flexed, and also the metacarpo-phalangeal joint flexed, and the first metacarpal bone, or the thenar eminence, extended or abducted. Carry your finger from the middle of the wrist three-quarters of an inch forward. Then carry your finger along the middle of the thenar eminence, and that is the surface marking of the deep flexor tendon. If you keep this in mind in looking for this tendon after it has been divided by injury, you will come right down on it without needlessly destroying the important small or intrinsic muscles of the thenar eminence. In close relationship to this long flexor tendon is the important motor branch of the median nerve and two smaller sensory branches.

Look at the hand once more, with the palmar surface facing the eye, and looking at the thumb with the metacarpo-phalangeal joint flexed and the interphalangeal joint extended. Put your finger on the lateral margin of the first or proximal phalange. In a general way, on this margin are inserted two

important tendons: the abductor pollicis and the outer head of the short flexor of the thumb. Put your finger now on the inner or ulnar lateral margin of the first phalange, and here are inserted a part of the transverse oblique adductor muscle and the inner half of the short flexor, or the flexor brevis muscle. Going down the middle pathway, at the base of these four structures just named passes the long flexor tendon. Never more than a half-inch laterally to each side of this long flexor tendon are the quite important digital nerves, which are sensory nerves.

Here, it may be stated, extension and abduction are combined motions; flexion and adduction are combined motions. And now comes opponens action. That does not mean approximation of the palmar surface of the thumb to the palmar surface of each distal phalangeal area, but it means the bringing together of the tip of the thumb to the tip of each finger. That opponens action is a combination of, first, slight extension and abduction, because obviously you could not bring the tip of the thumb and any finger together with the thumb flexed and fully adducted or bent across the palm of the hand. Then comes flexion and some degree of adduction, so that the tip of the thumb and each finger do come together. The important thenar motor branch of the median nerve supplies the opponens pollicis muscle.

Look at the hand once more. Flex the interphalangeal joint of the thumb and the metcarpophalangeal joint with the first metacarpal bone not fully but three-quarters abducted. Drop the tip of a finger from the tip of the thumb down directly to where it strikes the thenar eminence. That is very close to this underlying very important motor branch of the median nerve.

With injuries at the wrist or at the base of the palm of the hand, or in the thenar eminence, you must be prepared to diagnose accurately muscle or tendon injuries, or loss of muscle or tendon action because of nerve injuries.

Very briefly, the diagnosis of these nerve injuries will be considered in a few moments.

Bone Injuries

In connection with bone injuries, one thinks at once of the X-Ray. Before an X-Ray may be obtainable, as part of primary treatment, we must be prepared to recognize massive dislocations of the hand on the wrist, and be prepared to reduce that dislocation, which may be done without too much difficulty unless it is associated with comminuted fractures at the wrist joint or in the joints formed by the distal row of carpal bones and the adjacent bases of the metacarpal bones. Before an X-Ray may be obtainable, if the patient or a coworker has not already, and at times very well, straightened out an interphalangeal dislocation, we must be prepared to do that. The angle of the shaft of a metacarpal bone should be kept in mind. Depressions in the metacarpal bone most often associated with a depression of the distal end with a dropped knuckle, so-called, may be easily palpated and a corrective splint in proper position applied before an X-Ray is obtainable. A complete subluxation of the proximal end of one phalanx beneath the distal end of another is at times seen. This is associated with a rupture of the overlying extensor structure of the finger, and may readily be detected without the aid of an X-Ray. There is no definite rule which can be laid down as to the necessity for X-Ray examination. That is largely a question of one's experience and judgment; and it seems the more experience one has and the better one's judgment becomes, the more frequently are X-Ray examinations advised and obtained. Certainly a little laceration by a pen-knife at the tip of the finger or a puncture wound caused by a lead pencil on the palmar surface of the finger, or the laceration on the back of the butcher's hand caused by a piece of chicken bone as he dresses the chicken, —ordinarily such wounds would not make one consider X-Ray examination necessary.

This discussion is concerned with the diagnosis and primary treatment of hand injuries. However, it may not be out of place at this point to state that before incisions are made in any part of the hand, in the treatment of sepsis, including the formation of pus, an X-Ray examination should be made. Perhaps everyone who has had much experience with swollen, painful hands has opened the dorsal aspect of a hand to evacuate pus, and none was found. Clotted or free blood was found and then an X-Ray picture was obtained and for the first time the diagnosis of fracture was made.

No worth-while rule seems to have thus far been established which would prevent carpal scaphoid fractures being treated for sprains for variable periods of time before an X-Ray revealed a true fracture. At first many of these fractures are not displaced and are amenable to treatment. Use of the wrist and hand, and the patient working as long as he could go after the accident, results in displacement of carpal scaphoid or navicular fractures with extremely long periods of disability resulting therefrom.

Nerve Injuries

The nerves of the hand which are injured by accident are three in number: First, the radial, second the ulnar, and third the median nerve. Radial nerve injuries, where the wound is confined to the wrist or hand, do not result in motor dysfunction, and therefore movements of the fingers

continued on next page

are not measurably affected. The radial nerve, anastomosing as it does with the sensory branch of the ulnar nerve on the back of the hand, may be injured, and occasionally is the focus of injury which terminates in a condition referred to as causalgia. *The ulnar nerve* is unfortunately frequently injured, and the word "unfortunately" is used because it is considerably more difficult to obtain restoration of function following repair of this nerve than in cases of median nerve injury.

Please look at your hand. Feel the lower end of the ulna and the smallest of the carpal bones, the pisiform. Put your index finger on the center of the beginning of the palm of the hand, that is, just in front of the main crease in the skin at the wrist joint. Draw a line from the head of the ulna to the point at the base of the palm of the hand. A laceration or puncture wound a half-inch or less in depth, and seldom deeper than that, which traverses that line, is pretty sure to injure the ulnar nerve.

We are not at the moment considering ulnar nerve injuries in the forearm, or at the elbow, or higher up. That wound just referred to injures the ulnar nerve because it is superficially placed and it lies above the surface of the anterior carpal ligament. That is the more important part of the ulnar nerve. A somewhat less important and easily recognized branch of the main trunk of the ulnar nerve comes off frequently two and seldom more than three finger's breaths above, or proximal to, the distal end of the carpal bones. The larger and frequently injured trunk of the ulnar nerve supplies all the interossei muscles and two lumbrical muscles, and the adductor muscle of the thenar eminence, and one-half of the short flexor of the thumb. The action of these muscles just named has been outlined above. If there are no injuries in the palm of the hand, and if the fingers cannot spread apart or come together so the sides of the fingers touch one another, with a wound at the wrist, the ulnar nerve has been divided. Diagnosis of this injury must be accurately made.

The median nerve is often injured. Look at your hand, with the palmar surface facing you. Place your finger on the skin in the middle of the wrist joint or carpal region. Move the tip of your finger back and forth a little in a transverse direction. You feel a tendon moving beneath the finger. That is the palmaris longus and so far as function is concerned it is not extremely important. It is very important as a landmark because just beneath it and a thin layer of fat and connective tissue is the median nerve. It is larger than the ulnar; it is more deeply situated. As already stated, it passes through the carpal canal, and it is quite amenable to surgical treatment. The longer the period of time which elapses following injury to these nerves before surgical treatment is carried out for their repair, the poorer the end result may be. It is therefore unfortunate that as part of primary surgical treatment nerve sutures at times should not be attempted.

Follow this median nerve through the carpal canal. It comes into the palm and lies always beneath the palmar fascia or palmar aponeurosis. In injuries involving laceration of this palmar fascia, —that is, when you look into the wound and see the edges of the palmar fascia, you must be suspicious of median nerve injury. It has been stated above that the median nerve in the palm makes possible motion in one-half of the short flexor of the thumb and the abductor of the thumb. It is the entire nerve supply to the opponens pollicis muscle, and it supplies the first and second lumbricals. It also gives off sensory branches to the sides of the thumb, the second, the third, and one-half the fourth finger. Final diagnosis of nerve injuries should not depend upon varying degrees of sensation or lack of it.

Right after the accident happens the patient is naturally not in a tranquil state of mind and has great anxiety about the outcome of an injury, particularly if it is considered at all serious. At that time the patient's interpretation of degrees of sensation present may be very erroneous.

Injuries affecting the radial, ulnar and median nerves in the hand have been outlined. It may be well to emphasize at this point that although both the median and ulnar nerves have been divided at the level of the wrist, nevertheless the patient may grasp and hold onto the handle of a hammer or two fingers of your hand. The reason for that obviously is that the motor supply of all the superficial and deep flexors of the fingers is given off at a level above the wrist joint or the base of the palm of the hand.

Blood Vessel Injuries

It may be correctly stated that very close to the nerves named above there are important blood vessels. A possible exception to this statement is in regard to the median nerve with which, as it passes through the carpal canal, there is no large blood vessel. The ulnar artery lies very close to the ulnar nerve, and it is very small, relatively speaking, even in the adult.

Look at your hand, with the fingers widely spread apart. Draw a line from the web of the extended thumb to the distal end of the fifth metacarpal bone. That marks the position of the underlying superficial palmar arch which sends off quite large branches. From this line just named, carry forward lines to the mid-point of the palmer edge of the web between each of two fingers. That is the surface marking of the branches of the superficial palmar arch and at the mid-point of the web just referred to these branches divide, sending off

branches to the sides of the fingers. Directly associated with these blood vessels in the palm and in the fingers are nerves, none of which in the adult is much smaller than the average wooden toothpick in diameter, and therefore they are not difficult to recognize. Diagnosis of blood vessel injuries is obviously closely allied to diagnosis of nerve injuries in the palm, since these two structures lie so close together.

Very carefully carried out suturing of all layers of the skin in the palm of the hand in which no tendon or muscle is injured, may result in a sloughing wound of the palm from a hematoma which forms as a result of division of an important branch of either the superficial or the deep palmar arch. In a general way, the deep palmar arch lies one finger's breadth proximal to the superficial, and is very close to the palmar surface of the metacarpal bones.

In wounds of the wrist it is indeed important to make diagnosis as to division of both the ulnar and the radial arteries. It is true that at times both of these large vessels may be ligated at the wrist and still have sufficient blood supply to maintain viable the structures of the palm and the fingers.

Some years ago we carried out a series of dissections to determine the absence of typical radial and ulnar arteries. In seventy extremities examined, but two were found in which there was a markedly anomalous development of branches of the brachial artery. It is unimportant herein to consider these anomalies. It is important to be sure of the blood supply before deciding on treatment, particularly with reference to viability of muscle and overlying skin and especially before proceeding with skin grafts as part of a primary surgical procedure.

Treatment

It has already been stated that the unbroken skin is quite resistant to infection. Once the skin is broken, all underlying structures are exposed to infection. Every wound is potentially infected. The time which elapses between the creation of a wound to the time it is properly cleansed is the danger zone time, and the longer that time is, the greater the likelihood of serious infection. That statement is true today, notwithstanding sulfa drugs and penicillin. Some sort of tourniquet is frequently necessary to stop bleeding. The best form of tourniquet is a blood pressure cuff placed smoothly about the upper arm, with the shoulder joint halfway between complete internal and external rotation and the forearm halfway between complete pronation and supination.

At the present time and apparently for some time to come, an ordinary leather belt, or a piece of rubber tubing, or a handkerchief will be the forms of tourniquet used in industrial plants where a coworker is the one who first puts on the tourniquet. Not infrequently when the doctor first sees the patient bleeding does not stop until one of these just named materials used for tourniquets is removed. Obviously, the material used and the use of it did not control blood coming into a part from a fairly large artery. Marked venous bleeding is encountered. Loss of blood may result in loss of life and must be controlled.

In the industrial plant, through the loud speaker already referred to, all who are working may be taught the necessity of covering a wound with something, and the cleaner the something, the better. It might seem gross error to say a wound had better be covered with a soiled handkerchief, not to speak of desirable clean waste always available in an industrial plant, rather than leave the wound open while the patient is being transferred to a doctor's office or even the first aid room in the plant.

Once the trained industrial nurse, or the physician, sees the wound, very little choice of treatment is at one's disposal. So far as the wound is concerned, it must be made clean and tissues must not be injured so that they will become non-viable by materials used in cleansing the wound. Regardless of conditions in which the wound was made, it must be promptly cleansed, if the cleansing of it does not endanger life, as, for example in a patient in serious shock. No attempt will be made to discuss shock treatment. When the nurse or the doctor sees the wound, it must be covered by sterile gauze. A great many of these wounds may be thoroughly cleansed without the use of general or local anesthetics. A nurse or a physician would not enter an operating room with operation in progress without a mask on. The physician or nurse should have a mask on while cleansing these wounds. If at all possible, rubber gloves should be worn. The area about the wound is cleansed with bland white soap and warm water. Cotton or soft gauze may be used. A brush should not be used. Immersing the injured hand and forearm in a warm water bath may be a necessity. It is better, however, to cleanse the area about the wound, and that means all about it,—all of the surfaces of the forearm and hand, including shaving of these parts, with running water which is not too hot and not cold. Ordinary tap water from a faucet in the factory or first aid room or accident room in the hospital may be used with a considerable degree of safety. We use not less than a hundred quarts of warm sterile water, which is being poured slowly about the wound and then into the wound, before any primary operative procedure is undertaken. Those who have had experience in these measures used in cleaning wounds will verify the statement that the procedures outlined thus far may, in many cases, be carried out without anesthetic.

continued on page 891

HORMONES IN TUBERCULOSIS

PETER F. HARRINGTON, M.D.

The Author. *Peter F. Harrington, M.D., of Providence. Director of Tuberculosis, Providence Health Department Chief, Tuberculosis Division, Chas. V. Chapin Hospital.*

HUMAN tuberculosis in many respects is as much an enigma today as it was several years ago. Even now our most reliable methods of treatment still are bed rest and the surgical procedures that augment bed rest, i.e. pneumothorax, phrenic nerve operations, and more recently pneumoperitoneum, thoracoplasty, and pneumonectomy. All of these are directed solely toward an attempt to limit the activity of the lungs involved.

Individual resistance is the greatest single factor in a person's ability to withstand tuberculous infection. It is obvious that to date we have lung rest and adequate nutrition as the only reliable methods of improving this one, single, all important factor,—patient resistance. Bodily resistance has been considered as undefinable. Perhaps more extensive investigation of those bodily organs which play a dominant role in all human activity, viz. the endocrine glands might provide an adequate definition and solve the riddle which still puzzles all of us.

There is relatively little literature pertaining to the role of endocrine glands in human tuberculous infection. There is presented herewith a resume of some of the outstanding contributions to this seemingly important subject.

Adrenals

The most important chronic disorder of the adrenal glands is Addison's disease. 50% of patients with recognized Addison's disease have the affliction as a result of tuberculosis. Thompson[1] further states that patients with Addison's disease are particularly prone to develop upper respiratory infections, which indirectly might suggest a further relationship between the adrenal glands and the lungs.

Pottenger and Pottenger[2] reported a study of the effect produced by cortical extract given to guinea pigs inoculated with tubercle bacilli. They compared the results to controls inoculated with tubercle bacilli but not treated, and other controls inoculated but treated with insulin. They reported that 12 of 43 guinea pigs so treated with adrenal cortical extract for periods varying from ten days to the lifetime of the animal showed at necropsy no evidence of tuberculous infection. In the remaining treated animals the infection developed but it differed from the untreated in that it was milder and less extensive. Those inoculated but not treated with adrenal hormone all became infected. This tends to show that the adrenals have some relationship to tuberculosis in the laboratory animal. It is surprising that such an interesting study was not followed by further like experiments.

Hypophysis

Steinbach, Duca, and Molomut[3] investigated the resistance of hypophysectomized albino rats to tuberculosis. Twenty-four hypophysectomized albino rats were infected intraperitoneally with 1 mgm of a pathogenic bovine strain (BI) of the bacilli. These developed more severe tuberculosis than did the controls not operated upon.

Since the ablation of the hypophysis caused noteworthy changes in all other endocrine glands, e.g. the adrenals, spleen, and lymphoid tissues, the specific basis for the lowered resistance to tuberculosis which is manifested in hypophysectomized rats is difficult to determine, and conceivably may be due to the atrophy which may occur in one or all of these organs.

Here again we have definite evidence of an intimate relationship between endocrine activity and tuberculous infection.

Pancreas

The frequency of combined diabetes mellitus and pulmonary tuberculosis is obvious to everybody. Root[4] in 1934 reporting the morbidity of 1651 diabetic patients showed that tuberculosis was three times as common among diabetics as among the general populace. In this he confirmed a previous report by Banzai[5] who in 1931 reported that tuberculosis was three times as common among diabetics as among the general population. Foley and Andasco,[6] reported 28 cases in which 22 definitely had diabetes preceding tuberculosis and in three the diabetes and tuberculosis were discovered at the same time and therefore, it was impossible to discover which preceded. It is obvious that we can admit some relationship, between the endocrine activity of the Isles of angerhans and pulmonary tubercu-

losis, and coincidentally agree that the endocrine disorder frequently precedes this affliction.

Thyroid

Storey,[7] in giving an extensive review of the literature points out that the general observations of many well conducted studies were that (a) a diffusely enlarged but clinically non-toxic thyroid gland gives a relatively favorable prognosis to a patient with tuberculosis; (b) that the thyroid enlargement cannot be ascribed to the action of tuberculosis.

From this we may suppose that the thyroid glands play some part in tuberculosis activity.

Ovaries

No direct relationship between tuberculosis and ovarian activity has been prominently mentioned in the literature in recent years. Faulkner,[8] however, reported a carefully scientifically conducted study relating to the bactericidal activity of diethylstilbestrol and 4-hydroxy-dyethylstilbene to tubercule bacilli in vitro. The bacilli were killed in two hours in approximately 1:5000 concentration, and at variable but consistent times with other dilutions. Animal inoculations of the treated organisms were made to prove the reported bactericidal effect of these solutions. This does not prove a great deal, in as much as, both substances have a bactericidal activity against many other organisms. It does show that there is some relationship between synthetic ovarian like substances and tubercle bacilli.

Articles pertaining to other endocrine glands, viz. para-thyroids, pineal, testes, etc., and there relationship to human or experimental tuberculosis were difficult to find even after exhaustive search. It is possible there are some well conducted studies in the foreign literature which have escaped notice.

Justification for the use of the adrenal cortical hormone rather than any other may be found in the following observations.

It is true, in certain cases of hypo-function of the Adrenals that laboratory tests aid in establishing the diagnosis. Tests revealing, for example, lowered blood sodium; increased blood urea or non-protein nitrogen; lowered blood volume etc., are considered evidence supporting a diagnosis of Addison's disease. It is recognized, however, that these bodily alterations may be the effect of only certain adrenal functions. No method for the measurement of adrenal disorders accompanied by changes in carbohydrate metabolism, muscular strength and resistance to infections and intoxications have as yet been perfected. There is a possibility that other hormones of the adrenal may be solely affected, while the now detectable one remains intact.

Hormones Versus Anti-Biotics

Much investigation with anti-biotics in tuberculosis is being done. The best conducted studies have revealed that many chemotherapeutic agents in the sulfonamide family, (1) definitely alter tuberculosis in the guinea pig, and (2) that a like result is not obtained in tuberculosis in humans treated with the same drugs. It follows that there is a possibility that future investigations after toxicity and tolerance have been determined may have to be made on patients with tuberculosis rather than solely on laboratory animals.

It is stimulating to read the suggestion by Pinner[9] that "it seems questionable, however, whether extensive animal experiments should be made to tests its (chemotherapy) efficacy in experimental tuberculosis". He points out that promin, e.g. is effective in the guinea pig but essentially ineffective in humans. It may, therefore, be desirable and preferable to omit the study in tuberculous animals and test the anti-tuberculous action in patients (in reference to chemotherapeutic agents). "Therapeutic effects of a truly efficacious chemotherapeutic agent are not likely to depend for proof on elaborate control series."

CASE REPORT:

R. C. an 18 year old white female was in good health until December 1, 1941, at which time she began to experience weight loss, weakness and productive cough. Employed in a sedentary job in a jewelry shop she was unable to continue. Two weeks later she developed a fever and a general increase in her symptoms with hemoptysis and pain in the lower right chest. She was diagnosed as having pneumonia and was treated at home with sulfonamides. No improvement ensued and she was admitted to the Tuberculosis Ward at the Charles V. Chapin Hospital January 14, 1942.

Physical examination on admission revealed a fairly well developed but poorly nourished white female, acutely ill, with a temperature of 101° F, and weighing 100 pounds. Except for her general appearance and the thoracic findings her physical examination was essentially normal. There was a definite lag of the right hemithorax during respiration. Dullness, bronchial breathing, increased vocal and tactile fremitus and scattered coarse moist rales were the findings over the right lower chest. Laboratory Data: Urinalysis—Normal; Blood Wassermann—Negative; Blood glucose—115/mg. per 100 cc; N.P.N. 32/mg. per 100 cc; Sedimentation (corrected) 47 mm 1 hour; Hb. 68%; R.B.C. 4, 150,000; W.B.C. 12,150; 77% p.m.l; 14% s.l., 5% 1.1; 3% mon.; 1% eos. Sputum was positive for tubercle bacilli and negative for hemolytic streptococcus and B. influenzae. X-ray shows consolidation of the right lower lobe.

Diagnosis: Tuberculous pneumonia.

continued on next page

Course:

Her course from the time of admission was steadily downhill. Pneumo thorax was not considered advisable although frequently discussed. Because of her poor progress and the usually poor prognosis of tuberculous pneumonia, some other form of therapy that might aid and still not hinder her chances for recovery was sought. Because of the failure of sulfonamides prior to admission and the universally accepted knowledge that they are of no value in tuberculosis, no further trial was immediately decided upon. The patient continued to have a daily temperature elevation to 100°-101° F. Her sputum remained positive; her weight decreased to 93 pounds. On April 20, three months following admission another course of sulfonamide was decided upon. On April 25 no improvement had followed adequate initial and continued doses of sulphathiabole. It was, therefore, discontinued May 12. Because of a strong conviction that hormones play a part in many cases of tuberculosis it was decided that adrenal cortical hormone be given frequently. 1 cc. of an acceptable adrenal cortical hormone was given three times weekly beginning May 2, 1942 until August 3, 1942. At that time, because of the marked clinical improvement the dose was reduced to 1 cc. weekly and so continued until March 15, 1943. Sodium cloride 15 gms. p.o. was administered daily. As the accompanying chart shows her temperature remained elevated to 100°-102° F. daily until May 17, 1942, 5 days after sulfathiazole was discontinued and 2 weeks after adrenal cortical therapy was instituted the daily fluctuations were no greater than 99.5° except for a rare 100.2° until June 14, 1942 after which the daily temperature elevation did not exceed normal more than 12 times until discharge. Weight loss continued until it reached 89 pounds June 26, after which it steadily increased to 130 pounds at the time of discharge in June 1943. The sputum remained positive until September 1942. After which monthly specimens were negative on smear, and gastric lavage was negative in May 1943. Other treatment consisted of a high vitamin, high calcium, and high protein diet.

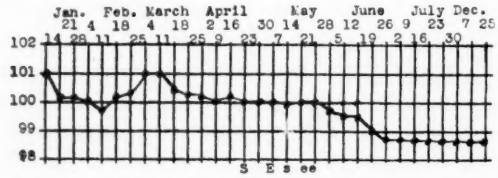

Chart showing temperature curve in relation to the administration of sulfathiazole and hormone.

e: Adrenal cortical hormone begun.
E: Hormone continued until March 1943.
s: Sulfathiazole begun.
S: Sulfathiazole discontinued.

Patient left the hospital against advice on June 23, 1943. The X-rays remained essentially unchanged until that taken on June 9, 1942 which showed definite evidence of resorption of the exudate. Frequent X-rays taken thereafter showed continued clearing of the lesion so that at the time of discharge the right lung was completely cleared of the density. An X-ray taken on November 5, 1945 showed no evidence of active disease and a minimal evidence of a healed lesion.

Comment:

There is universally poor results in patients with tuberculous pneumonia, particularly, in this age group. Prior to the patient's admission another white female had died of tuberculous pneumonia. This latter patient's course showed a steady downhill trend from the time of admission and it was evident R.C.'s course was following the same pattern. After the institution of adrenal cortical hormone, R.C. recovered fully. It is not claimed that adrenal cortical hormone was the deciding factor in her recovery. It was gratifying to know that the trend of the disease suddenly changed and the patient got well. It is my feeling that the role of the hormones in tuberculosis has not been completely explored. Although it is wise and proper to devote much research to anti-biotics, it is possible that a very vital influencing factor in human tuberculosis is being passed over too lightly.

Summary

1. It is suggested that further studies of endocrine tuberculosis relationship are warranted.
2. An attempt is made to show that such a relationship exists and is important.
3. A case of tuberculosis pneumonia treated with adrenal cortical hormone is reported.

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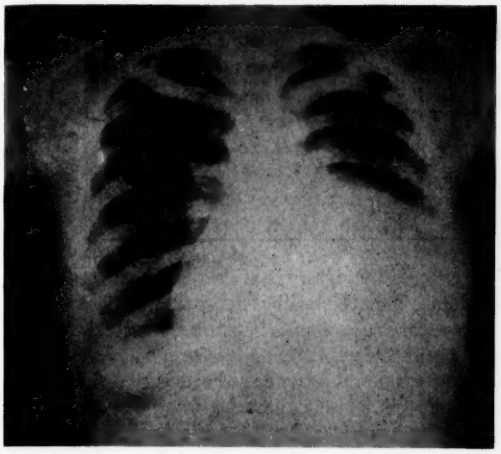

FIGURE 1 *Adm. film 1-15-42 showing consolidation of lower half of right lung field.*

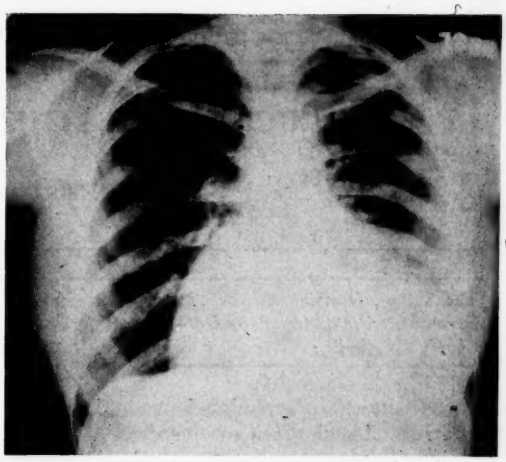

FIGURE 4 *Film 11-42, 6 months after initial use of hormone showing marked clearing of lesion.*

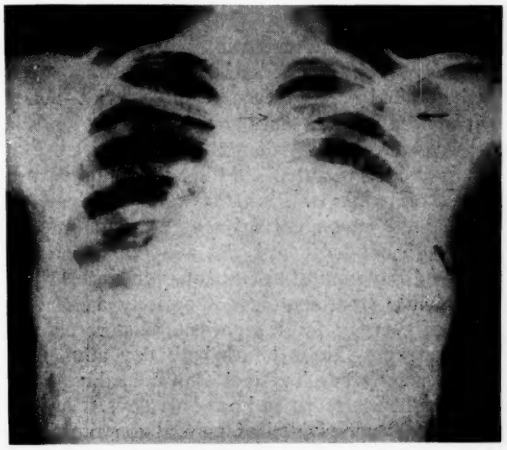

FIGURE 2 *Film 3 months after admission showing further involvement of the right lung.*

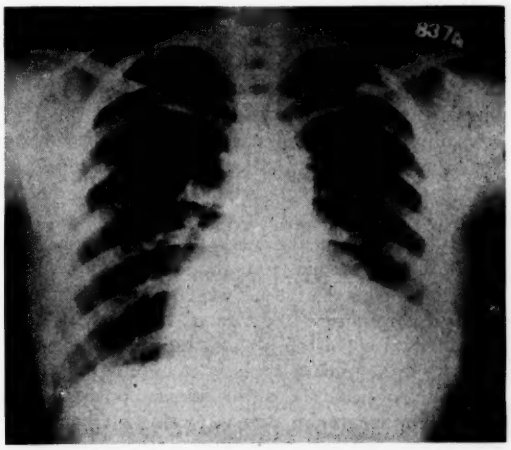

FIGURE 5 *Film 3-43 shows complete clearing of lesion.*

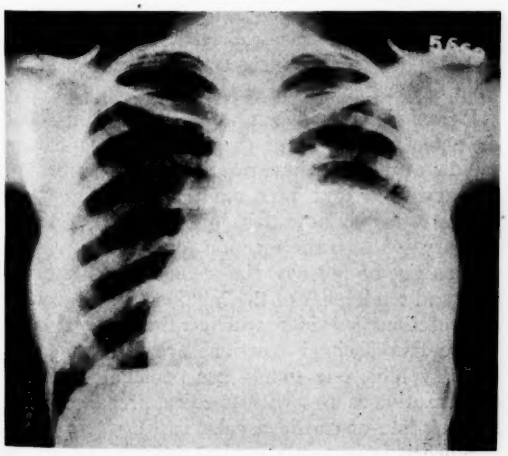

FIGURE 3 *Film 6-9-42, 5 weeks after hormone instituted, shows beginning resorption of exudate.*

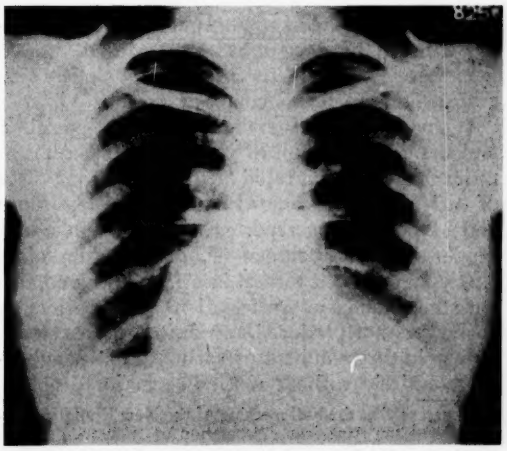

FIGURE 6 *Film 11-45 shows the lung fields to have remained free of any signs of reactivation.*

PENICILLIN TREATMENT OF EARLY SYPHILIS*

D. WILLIAM J. BELL, M.D.

The Author. *D. William J. Bell, M.D., of Providence. Former Assistant Superintendent of the Charles V. Chapin Hospital.*

THE treatment of syphilis belongs to the modern rapidly changing era of therapeutics, for the first successful medication was an arsenic preparation called salvarsan and introduced by Ehrlich only forty years ago. Since that time many new drugs have been discovered and some of them have been useful in the treatment of syphilis but its cure has required a course of weekly injections over a period of at least one or two years. This prolonged course of treatment has always taxed the ingenuity of physicians and social agencies to keep the patient returning regularly for treatment, when for many weeks and months the patient has felt and appeared to himself to be perfectly well. Accordingly, syphilologists have searched for many years for a rapid method of treating the luetic patient.

The first satisfactory method of curing syphilis in a short period of time was introduced by Dr. Louis Chargin of Mount Sinai Hospital in1933.[1] His method consisted of hospitalizing the case of primary or secondary syphilis and giving him massive doses of neoarshenamine intravenously for five days. The treatment was very efficient in curing the disease, but its toxic effects were so dangerous that the neoarsphenamine was soon replaced by mapharsen[2] which also proved to be efficient for a five-day treatment of early syphilis. The rapid mapharsen method of treatment carried a less serious element of danger but still cases developed hemorrhagic encephalitis from the arsenic and several patients with this complication died.

It was not until after the discovery of penicillin and the determination of its spirocheticidal properties that a safe but rapid method of treating cases of early syphilis became available. In 1943, Moore and Mahoney[3] first reported that penicillin would render the primary sore of syphilis free from spirochetes and cause it to heal in a few days, and also cure the secondary manifestations. Since penicillin so far has not produced any serious toxic effects, its use in the treatment of early syphilis is apparently entirely without risk. The major problem, however, is the determination of the proper dosage schedule, and this will remain unsettled for some time in cases of syphilis because the criteria of cure is difficult to establish and it is necessary to observe a case for several years to be certain that the disease is cured.

At the Charles V. Chapin Hospital, penicillin therapy of early syphilis was welcomed as it removed the fear of toxic effects that was ever present under massive arsenotherapy[4] and the first patient was treated with penicillin in September 1944. At that time, 1,200,000 units of penicillin were given in doses of 20,000 units intramuscularly every three hours for seven and one-half days, as recommended by the United States Public Health Service. After the first 16 patients were treated, the dosage was increased because 3 patients showed a relapse in the first four months. At this time the Armed Forces' schedule of 2,400,000 units in doses of 40,000 units intramuscularly every three hours for seven and one-half days was adopted and it has remained our plan of treatment ever since.

Penicillin treatment is not entirely a pleasant form of therapy for the patient must receive an injection every three hours both day and night. That means that each patient is awakened regularly every night for seven and one-half days. Some of the patients complained of pain at the site of injection but in no case was it necessary to discontinue treatment. No reactions to the drug were encountered during treatment and the patients were discharged immediately following their last injection. Only one case reported any late reaction and that was an urticaria which developed about eight days after discharge.

Herksheimer reactions were observed in about the same proportion of cases as with mapharsen rapid treatment[4]. These reactions took the form of primary fever and intensified secondary rash. It is interesting to note that in 2 females who had primary syphilis, the reaction took the form of a sudden rise of fever on the second day and severe pain and tenderness of the inguinal lymph glands. All reactions subsided with continued treatment. While Herksheimer reactions are not serious in early syphilis, one should use penicillin with the same caution as used with arsenical preparations, if treating late or cardiovascular cases.

Since it is impossible to establish a criteria of

* Presented at the Fall meeting of the New England Conference of the American Association of Industrial Physicians, at Pawtucket, R. I., October 10, 1945.

cure in syphilis by observing the disappearance of bacteria or the healing of lesions, it is necessary to approach the follow-up of cases by an indirect method. In this series of cases, the Wassermann and Hinton reactions on serial dilutions of the patient's blood serum served as an index of the progress in each case. These examinations were made at two-week intervals for six months and then at monthly intervals for the remainder of a year. A diminishing titre of the reactions denoted satisfactory progress and a rise in titre indicated failure. Insufficient time has elapsed since this series of cases began treatment to permit a complete follow-up, but it is proposed to observe all patients at six-month intervals for a period of five years.

A total of 108 patients have received penicillin therapy for primary or secondary syphilis at the Charles V. Chapin Hospital since September 1944. Of these, only 62 patients have returned sufficiently often to be of any value for follow-up at the present time. Twelve of these patients received 1,200,000 units of penicillin and the remaining 50 patients received 2,400,000 units. The primary lesions and secondary rashes or mucous patches had healed in all patients before the completion of treatment so that they were discharged from the hospital in a non-infectious state.

The strength of the Wassermann reaction falls off slowly after the completion of treatment and rarely reaches negative in less than four weeks. The rapidity with which the serology becomes negative is in direct proportion to the strength of the reaction before treatment, and this is also related to the length of time between infection and the beginning of treatment. If the Wassermann and Hinton reactions have not become negative within six months after treatment, it is considered that the treatment has failed and the patient is readmitted for another course.

Three patients of the 12 who were followed on the 1,200,000 unit dosage were considered failures and were given a second course of treatment. Under the 2,400,000 unit dose plan, 4 patients out of 26 who have been followed for at least three months have failed to show satisfactory improvement in the Wassermann titre and have been readmitted for more treatment. Although none of the failures in either group of patients has shown a new primary or recurrent secondary lesion, at least one of the second group is known to have contracted gonorrhea since her first treatment and therefore may definitely be a reinfection instead of a relapse.

Chart[1] shows that the follow-up of cases who receive rapid treatment is a major problem. The type of person with whom we are dealing is such that many times it is difficult to locate them for they move about from one address to another and often their friends at the old address will not disclose their new abode. However, as more time

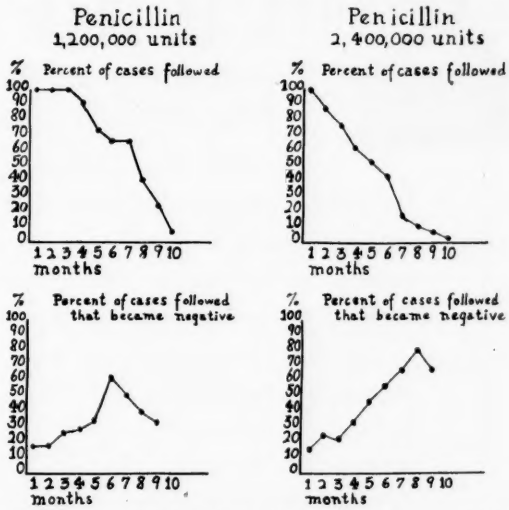

CHART 1. Graphs showing follow-up of cases in both groups of patients and the percentage of those followed that became negative.

elapses after treatment, probably many who are now delinquent will be located or may be referred for examination as sources of or exposure to other cases of veneral disease. As a result of the difficulty in following these patients, the fact that 62 per cent who became negative after the 1,200,000 units of penicillin as compared with the 75 per cent who became negative following 2,400,000 units is not of actual significance but together with the smaller proportion of relapses, it seems to indicate a trend of better results with the larger dosage.

Summary

1. One hundred and eight patients have received penicillin therapy for early syphilis at the Charles V. Chapin Hospital since September 1944.

2. There were no serious reactions to treatment and no fatalities.

3. Penicillin, like mapharsen, requires that the patient be hospitalized during his treatment and he is discharged back to the community in a non-infectious state.

4. Follow-up is still a major problem with syphilitic cases and in this series, insufficient time has elapsed to draw definite conclusions but 2,400,000 units of penicillin given in seven and one-half days seems to be preferable to 1,200,000 units given in the same length of time.

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continued on page 901

INDUSTRIAL MEDICINE is fast assuming its rightful position with the other branches of the healing art.

In all New England, and especially in Rhode Island with our high percentage of industry, we have the opportunity for our greatest advancement.

Every industrialist should of his own volition establish medical departments, the larger plants with departments singly, and the smaller plants combining at some conveniently located department in charge of a competent physician and nurse.

Elsewhere in this issue of the Journal you will find the minimum standards for medical departments set up by the American College of Surgeons. After an inspection and the carrying out of the prescribed regulations the certification is granted. Shortly, the American Association of Industrial Physicians will conduct their own inspection, taking over the duties of the American College of Surgeons.

A physician, and not necessarily a surgeon, should be in charge of these medical departments as the vast majority of the work should be pre-placement examinations, periodic re-examinations, sanitation of the plant, rehabilitation of veterans in industry, inspection of food trucks, cafeteria, etc.

The section on Industrial Medicine of the American Medical Association, has recently set up a standard of minimum requirements as to equipment that should be used, together with minimum requirements in physical examination and tests done in pre-placement work.

Not every physician or nurse is qualified to do industrial work. As any doctor in industry will point out he will have to have qualities other than doing good medical or surgical work, and especially he must be a good diplomat as he will have to please the employer, the immediate boss or supervisor, the family physician, relatives of the patient, and he must consult with the insurance carrier — all in addition to having first the interest of the patient at heart.

Medical schools are now starting courses in Industrial Medicine and shortly the American Association of Industrial Physicians will start to qualify all physicians doing industrial work. It is to be hoped that more of our members will take an active interest in the development of these programs of industrial medicine which are destined to play such a major part in the future medical care of the nation.

JOHN F. KENNEY, M.D.

President, New England Conference, American Association of Industrial Physicians

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THE FUTURE OF INDUSTRIAL MEDICINE IN RHODE ISLAND

RHODE ISLAND is the most highly industrialized State in the nation and it should be in the forefront in promoting Industrial Medicine.

We have 79 different types of manufacturers in 3,354 individual plants divided as follows:

3	plants	employ	5,000 or more persons
28	"	"	1,000 to 4,999
290	"	"	500 to 1,000
233	"	"	100 to 499

Thus we find that

554 plants employ over 100
2800 plants employ less than 100

According to the Department of Labor 288 major firms reported for 104,703 wage earners an average weekly payroll of $3,987,857.00. Statistics for the other 3,012 firms are not available.

Rhode Island also leads all other States as to wage earners engaged in manufacturing per 100 population with a figure of 148.

Connecticut employs 136 per 100 population
New Hampshire employs 113 per 100
Massachusetts employs 107 per 100 and the
United States figure is 59.

Why then does Industrial Medicine lag so far behind? The answer is obvious—2800 firms out of 3,354 employ less than 100 persons and therefore consider it impossible or impractical to supply industrial medical service. If we leave out the 3 firms with more than 5,000 employees, where industrial medical service is supplied, there remain 451 firms employing from 100 to 4,999 persons who should have some type of industrial medical service coverage. Many of them do but too many of them do not.

There are only 103 physicians (Members of the Rhode Island Medical Society) who are listed in doing part-time Industrial Medicine. This list includes also all who have only an occasional industrial accident injury as well as physicians who conduct regular mill clinics.

Other reasons for the lag in Industrial Medicine in Rhode Island are:

1. Manufacturers are not fully conversant with the benefits to Industry and Labor in a program of Industrial Health.
2. Too few physicians are fully conversant with the potentialities of Industrial Medicine.

In an attempt to remedy the conditions here, the Committee on Industrial Health of the Rhode Island Medical Society in cooperation with the Division of Industrial Hygiene, State Department of Health, held an Industrial Seminar. Subsequently the Rhode Island Society of Industrial Physicians and Surgeons was formed. This or-

continued on next page

ganization has conducted meetings in plants and in the Medical Library on Industrial Health. Through the cooperation of Brown University a postgraduate course in Industrial Health was inaugurated last fall and fairly well attended by industrialists, well attended by nurses and poorly attended by physicians. The war undoubtedly has had much to do with the lack of interest on the part of physicians in this State in the subject of Industrial Medicine but before Industrial Medicine can become a reality in Rhode Island it will be necessary to awaken the industrialists to the value of medical services in industry and to educate more physicians as to what constitute the basic principles as well as the theory and practice of Industrial Medicine.

The insurance companies have a large stake in the type of medical care given injured employees and it should be possible to arrange a combined meeting of insurance company executives, industrialists and physicians interested in Industrial Medicine where educational work of benefit to all concerned could be inaugurated.

The time is coming when Labor will enter the picture and demand better industrial medical service. Labor is already interested intensely in the problem of healthful working conditions and is very much aware of the contributions that have been made through the field of Industrial Health.

A Bill now in Congress would authorize United States Department of Labor to give funds to help State Labor Departments do a better job in health and safety. This indicates that Labor feels it can obtain better healthful conditions under Labor Departments than under Health Departments. Unless physicians, themselves, as well as industrialists realize their responsibility along these lines, forces from without the profession will take direction and shape the policies in this field.

The remedy lies in an immediate awakening of physicians, industrialists and insurance companies to the need for an active long range program of Industrial Health fitted to the particular pattern of Rhode Island industry. The cooperative effort of all concerned is necessary to develop such a program.

An interesting and a lucrative field of work awaits the physician interested in Medicine in Industry. Pre-employment physical examinations offer a challenge to diagnostic skill and present an opportunity for preventive medicine. Study of the plant hazards and methods to control and combat them, a periodic check-up as to the effects of hazards, the detection of tuberculosis as well as the chronic debilitating diseases of middle life and advancing years, are but a few of the opportunities for the skill of the physician.

Traumatic industrial accidents go to the physician associated in industry and challenge his ability to organize in an emergency. Industry also offers the physician an opportunity to develop his executive ability in conducting a Medical Department, the control of healthful working conditions, plant sanitation, rest and recreational facilities, lighting, ventilation, etc.

It should be possible to work out a plan whereby several small plants could group together and prorate the cost of industrial medical service and it should be worthwhile for some physicians to cover those plants on a cooperative basis.

Rhode Island as a leading State in an industrial nation must evolve, as its contribution to Industrial Medicine, a type of industrial medical care suited to its particular needs. The possibilities are limitless but the time for action is now. It is to be hoped that all physicians doing some industrial work will taken an active interest in the development of Industrial Medicine.

DR. DENNETT L. RICHARDSON

Dr. Richardson, on January 1st, 1946, will have completed thirty-eight years of hospital administration, and all of it in the City of Providence.

Dr. Richardson was born in Newport, Maine, in 1879; was graduated from Bates College in 1900 and from the University of Pennsylvania School of Medicine in 1905. At both of these institutions Dr. Richardson was an outstanding end on the varsity football teams, and those of us who saw him play will ever bear witness to his speed, his skill, his courage and his leadership on the football field.

On completing his medical course, Dr. Richardson entered the Rhode Island Hospital as an intern in 1905, where his outstanding knowledge of medicine and surgery early marked him as a physician capable of the highest skills and achievements. Following his two years internship he was appointed Assistant Superintendent, in which capacity he served with distinction until his appointment in 1909 as Superintendent of the Providence City Hospital, now the Charles V. Chapin Hospital.

Dr. Richardson's medical and administrative ability had been recognized by Dr. Charles V. Chapin, the Superintendent of Health in the City of Providence, and Dr. Chapin and Dr. Richardson worked out the plans for the Providence City Hospital, basing these plans on Dr. Chapin's theory that contagious diseases were contact diseases and not air borne—a theory which at that time was held questionable by even a good many so-called authorities.

In directing the Providence City Hospital, Dr. Richardson soon placed it among the very foremost of modern contagious hospitals, and in a practical and dramatic way demonstrated the validity of Dr. Chapin's theories. He soon became the logical suc-

cessor of the famous Charles V. Chapin in his knowledge and management of contagious diseases, and the Providence City Hospital was visited and imitated by health authorities from all over the world.

Following Dr. Chapin's death, Dr. Richardson was appointed Superintendent of Health in the City of Providence, and for several years held this position with great distinction.

During his whole medical career Dr. Richardson has been sought constantly in consultations regarding contagious diseases, and in the now almost forgotten days when diphtheria was rampant many a child's life was saved through this expert's judgment and technique in intubation.

In 1940, following the resignation of Dr. John M. Peters, Dr. Richardson was called back to the Rhode Island Hospital as Superintendent, and it is during his leadership that the plans for a new Rhode Island Hospital and the campaign for $5,000,000 have been developed and are being executed—a very great memorial to any man.

Throughout his medical career, this physician has been a frequent contributor to medical journals and in professional organizations. For many years he has written "Medical Facts and Theories" for the *Providence Journal and Evening Bulletin.*

In 1916-17 he was the second Vice President of the American Hospital Association; in 1929, he was Chairman of the Public Health Relations Committee of the same organization. Dr. Richardson was President of the New England Hospital Association in 1924 and again in 1929, and in 1940 was Chairman of its Children's Hospital Section. He is a charter member of the Hospital Association of Rhode Island and one of the original directors of the Hospital Service Corporation of Rhode Island. He is a member of the Providence Medical, Rhode Island Medical and American Medical Associations, and in 1920-21 was President of the Providence Medical Association.

This long list of medical achievements and leadership could be added to by the recounting of many other important medical offices and memberships that he held, but Dr. Richardson does not need detailed and fulsome praise. His outstanding contributions in the field of contagious diseases, in health education and in health and hospital administration are well known to all of us and have had a very great and important impact not only in the State of Rhode Island but also throughout the nation. His outstanding qualities of medical skill, rugged honesty and vigorous leadership have brought about enduring benefits in the whole health and hospital fields. It is not given to many medical men to have accomplished as much in their lifetime as it has been to Dr. Richardson. Our community is a better place to live in for his having been its outstanding health leader. The medical profession has been directed and stimulated by his fine example, and we who have been his contemporaries are proud to have had the privilege of working with him and having him for a friend. It is our privilege to salute him for his very great accomplishments, and to wish for him, when he has been relieved of some of the present heavy burdens—especially those placed upon him during the war years—a continuation of his most valuable career in health education.

FORTY EVENTFUL YEARS

The Rhode Island State Sanitorium at Wallum Lake celebrated the fortieth anniversary of its opening on October 28, 1945. In the presence of several hundred visitors, including national and State officials, distinguished physicians, former patients and friends, appropriate exercises were held and the hospital was open for inspection. Various speakers in tracing the evolution of the Sanitorium from a small, barely adequate, thoroughly isolated and often forgotten institution to its present status as a completely equipped up-to-date hospital for the efficient treatment of patients with tuberculosis in all its various stages, bore frequent repeated tribute to the late Dr. Harry Lee Barnes, who, as its first Superintendent, organized it and for nearly thirty years directed its destiny.

An attractive booklet memorializing and illustrating the development of the Sanitorium has also been published, and will be read with interest by every Rhode Island physician. The RHODE ISLAND MEDICAL JOURNAL congratulates Dr. U. E. Zambarano, the present Superintendent of the hospital, and his associates, and also the many friends of the hospital who have contributed to its development during the past forty years on this notable anniversary. The JOURNAL also heartily endorses the resolution drawn up by friends and employees of the State Sanitorium which is to be introduced at the next session of the General Assembly suggesting the change of the name of the State Sanitorium to the Barnes Memorial Hospital. Such a change will not only honor the physician who more than any other single individual was largely responsible for the successful development of the institution, but is also in keeping with the present trend to remove in some degree the unpleasant and often erroneous associations attached by the general public to all organizations labeled "state institutions."

HOLIDAY GREETINGS

Narragansett

BREWING COMPANY

CRANSTON, R.I.

"ON THE POST ROAD" © 1945 BY NARRAGANSETT BREWING CO.

TREATMENT OF INJURIES OF THE HAND

continued from page 879

After the area about the wound has been cleansed, the wound itself is then uncovered and cleansed and a diagnosis of underlying injuries is made and recorded. Up to this point the treatment is the same in nearly all cases. From here on the following must be considered in deciding upon further measures in primary operative treatment:

(1) Where the wound occurred. That is, the premises. Was it a relatively clean knife in the cutting room of a shoe factory? Was it a broken milk bottle injurying a child's wrist? If so, was it in a somewhat clean kitchen or in the barnyard or running across the lawn on which manure had been spread?

(2) Is it a puncture wound—a relatively clean incised wound, an extensive lacerated wound with avulsion of skin, a crushing wound as from a rock falling on a man in a trench? Was the wound created by a carding machine in a wooden mill, etc., etc.?

(3) How extensive is the wound? What structures considered above under the heading "Diagnosis" are injured? In determining the structures injured, an anesthetic is frequently necessary. When at all safe to use, a general anesthetic is preferable to local. Ether alone, or used with gas, is the safest general anesthetic. Obviously, procaine solution as a local anesthetic in a puncture wound is all that is needed. The wound is made an open wound, drainage may or may not be used, and in all puncture wounds sensitizing and later therapeutic doses of antitetanus and gas serums are used.

We have no fixed rule applicable to all hand injuries as to the use of these prophylactic preparations.

Foreign bodies, including pieces of clothing, strands of wool, glass, etc., should be removed. Care should be taken in lifting out of a wound with an instrument a piece of glass which may have curved its way around an important nerve or blood vessel. The wound should be sufficiently enlarged so the glass may be extracted without pulling it across or against adjacent structures.

Consideration has been given above to skin, muscles and tendons, bones, nerves and blood vessels. Intentionally, treatment of burns has not been included in this discussion. Avulsed skin, as for example the skin of the whole dorsum of the hand, after cleansing may be replaced and sutured without tension to adjacent skin edges or tacked with fine silk or wire sutures to underlying structures. Primary skin grafting on the avulsed bulbar surfaces of fingers has not given us such good results as have been obtained when grafting was done as a secondary and elective procedure. Exposed tendons, whether divided or not, must, if possible, be covered by skin available or grafted. When skin covering is not obtainable, fine mesh vaselined gauze may be used. If the wound is seen, or has been cleansed within six hours from the time it was created, various operative procedures as part of primary operative treatment may be carried out. We have had two cases—and only two—in which, with marked loss of tissue including loss of bone and loss of nerve tissue and loss of muscle and tendon tissue, we have carried out quite extensive primary operative procedures. In one of these (Mr. J. F. W. a segment of 4 cm. of ulna was removed, the divided ends held in position with chromic catgut, the separated ends of the fractured radius brought together with a bone plate, two tendons in the forearm repaired, the epineureum of the divided median nerve sutured, and the skin edges were brought together without tension. This man returned to work in February following the July 3rd on which he was injured, with a hand which he felt was quite useful, but in which there was 40 per cent loss of function.

In the second case, no sepsis followed primary operation, but an extensive dissection and nerve suture were necessary, with a fairly good result. At once it is recognized 40 per cent loss of use and fairly good result are not desirable phrases to be used in detailed description of end results. These phrases may be used, however, to describe the man's ability to get back to work and do the work he was doing before the accident happened. So far as the hand and the wrist are concerned, after the wound has been thoroughly cleansed and debrided, we do primary nerve sutures in a small percentage of cases in the presence of bone and tendon injuries. There are many capable surgeons who elect to do primary nerve suturing in a great many cases where tendons are divided and comminuted fractures are present. In clean incised wounds, or lacerated wounds without appreciable loss of tissue substance, we do primary nerve suturing if the gap between the divided ends of the nerve is not greater than 1 to 1.5 cm.; provided this gap can be overcome by mobilization of tissues in the forearm above or by moderate volar flexion of the wrist, the divided ends of the nerve may be brought together with no greater than 1/10 or 2/10 cm. gap between them.

Primary tendon sutures are very frequently done. No attempt is here made to describe various methods of tendon and nerve suturing. There are many treatises available on these subjects. Small metacarpal bone plates may be used in compound metacarpal fractures. Great care must be taken in the use of these plates not to injure the underlying deep palmar arch and the interosseous muscles. We do not use bone plates in either simple or compound fractures of phalanges. In both metacarpal

continued on page 901

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OTOMIDE

THE RHODE ISLAND SECOND INJURY FUND

EDWARD I. FRIEDMAN

The Author. *Edward I. Friedman of Providence. Chief, Division of Workmen's Compensation, Department of Labor, State of Rhode Island.*

THE Second Injury Indemnity Fund law was enacted for the purpose of creating employment opportunities for disabled workers who had suffered loss of certain specified members of their bodies. Prior to this such disabled workers were rarely able to obtain any employment because of the provisions of the Rhode Island Workmen's Compensation Act and its interpretations by our Supreme Court. Thus, our Workmen's Compensation Act acted as a bar to the employment of these disabled workers.

Under the old law the employer was penalized out of proportion to his responsibility when an employee who had previously lost a major member lost a similar major member in an industrial accident. The employee, by reason of these combined injuries, was presumed to be permanently totally disabled and the employer was required to pay permanent total disability compensation instead of being required to pay only for the specific loss and the disability caused by the injury which occurred in his plant. As a consequence, employers refused to hire such disabled workers, and the handicapped individuals were deprived of earning their livelihood.

Our Second Injury Indemnity Fund amendment stipulates, "Whenever an employee who has previously suffered a personal injury or disease or has a congenital condition which resulted in the loss, or the permanent incapacity, of one hand at or above the wrist or one foot at or above the ankle, or the reduction to 1-10th of normal vision of one eye with glasses or any definite permanent partial disability, sustains an injury within the meaning of this chapter resulting in the loss by severance, or the permanent incapacity of, a hand or foot or the reduction to 1-10th of normal vision in an eye which results in permanent total disability, in accordance with the provisions of subsections a, b, c, and d of article II, section 10 of this chapter, the employer shall be liable for the total disability caused by the subsequent injury, which shall be a period equal to that for which specific compensation is payable, ..."

Thus, the employer by this amendment has his liability limited to the disability caused by the second or subsequent injury alone, and he is not penalized by the law and is encouraged to hire men who have lost major members of their bodies. The disabled employee gains in a two-fold manner — first, he is not discriminated against in obtaining employment, and, second, if the disabled worker loses a second major member through an industrial accident he still is entitled to permanent total disability compensataion. After the employer pays for the results of the second injury the Second Injury Indemnity Fund pays the balance of the compensation until the maximum total disability compensation is paid.

For example, a one-eyed man goes to work for an employer, having lost his left eye either on the war front or in a previous accident, and he becomes involved in an industrial accident and loses his right eye, he is then presumed to be permanently totally disabled according to the Rhode Island Workmen's Compensation Act. Prior to the passage of the Second Injury Indemnity Fund law his employer at the time of the loss of his second eye would have to pay him up to $12,000 for permanent total disability and one hundred and twenty weeks specific compensation for the loss of the right eye at $20.00 a week if he earned $40.00 a week or more, making the employer's obligation $14,400, and medical expense. Under the law as it now exists the employer at the time of the second injury pays total disability compensation for only one hundred and twenty weeks and specific compensation for one hundred and twenty weeks — $2400 for total disability and $2400 for specific compensation. The difference between the $2400 total disability compensation and the $12,000 maximum total disability compensation provided under our Act is paid out of the Second Injury Indemnity Fund. In this way the employer at the time of the second injury is not penalized for a permanent total disability which is not solely his responsibility, and the injured worker is not penalized because he receives the maximum permanent total disability compensation provided by our Act, and was originally given the opportunity to engage in remunerative employment despite his handicap.

The same situation applies to a man who lost his arm in the armed forces or in a previous accident.

continued on page 895

the obligations of victory

Victory, too, imposes obligations. The fruits of our efforts and the sacrifices of the past four years will be determined by our actions today.

There is much to be done if we are in some small measure to repay those who fought for us.

For those who died there are families to care for; those who were hurt must be brought back to health; and even those who returned without physical injury need to be helped back to a normal peacetime existence.

". . . to the great task remaining before us."

BUY VICTORY BONDS

They finished their job; let's finish ours.

Upjohn

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THE RHODE ISLAND SECOND INJURY FUND

continued from page 893

In such a case the loss of his second arm would cause his employer to pay two hundred and fifty-five weeks total disability compensation and two hundred and fifty-five weeks specific compensation. If the man had been earning wages that would entitle him to the $20.00 maximum weekly compensation the employer would pay $5100 total disability compensation and $5100 specific compensation, and the Second Injury Indemnity Fund would then pay the difference between the $12,000 permanent total disability compensation provided by our law and the $5100 paid by the employer.

The purpose of the second injury fund is to protect employers who hire handicapped workers against a disproportionate loss, and to remove the cause for refusing employment to impaired persons on any grounds other than their qualification for the work to be performed.

In conclusion, it is important to note that the benefits of the Second Injury Indemnity Fund are not limited to workers whose handicaps were caused by occupationally-connected accidents, but can apply to those whose handicaps were caused by congenital defects, previous accident or disease or service with the armed forces. It does not apply, however, to persons who suffered previous injuries or defects not of a major character, such as hernia, back injury or similar types of disabilities.

MINIMUM STANDARD FOR MEDICAL SERVICE IN INDUSTRY

(Established by the American College of Surgeons)

1. The industrial establishment shall have an organized medical department or service with competent medical staff including consultants and also shall have adequate emergency, dispensary and hospital facilities and personnel to assure efficient care of the ill and injured.

2. Membership on the medical staff shall be restricted to physicians and surgeons who are (a) graduates from an acceptable medical school, with the degree of Doctor of Medicine, in good standing and licensed to practice in their respective states or provinces, (b) competent in the field of industrial medicine and traumatic surgery (c) worthy in character and in matters of professional ethics; in the latter connection the practice of the division of fees, under any guise whatsoever, shall be prohibited.

3. There shall be a system of accurate and complete records filed in an accessible manner, such records to include particularly a report of injury or illness, description of physical findings, treatment, estimated period of disability, and results, as well as other information pertinent to the case or required by statute for Workmen's Compensation claims or other purposes.

4. Patients requiring hospitalization shall be sent to institutions approved by the American College of Surgeons.

5. The medical department or service shall have general supervision over the sanitation of the plant and the health of all employees.

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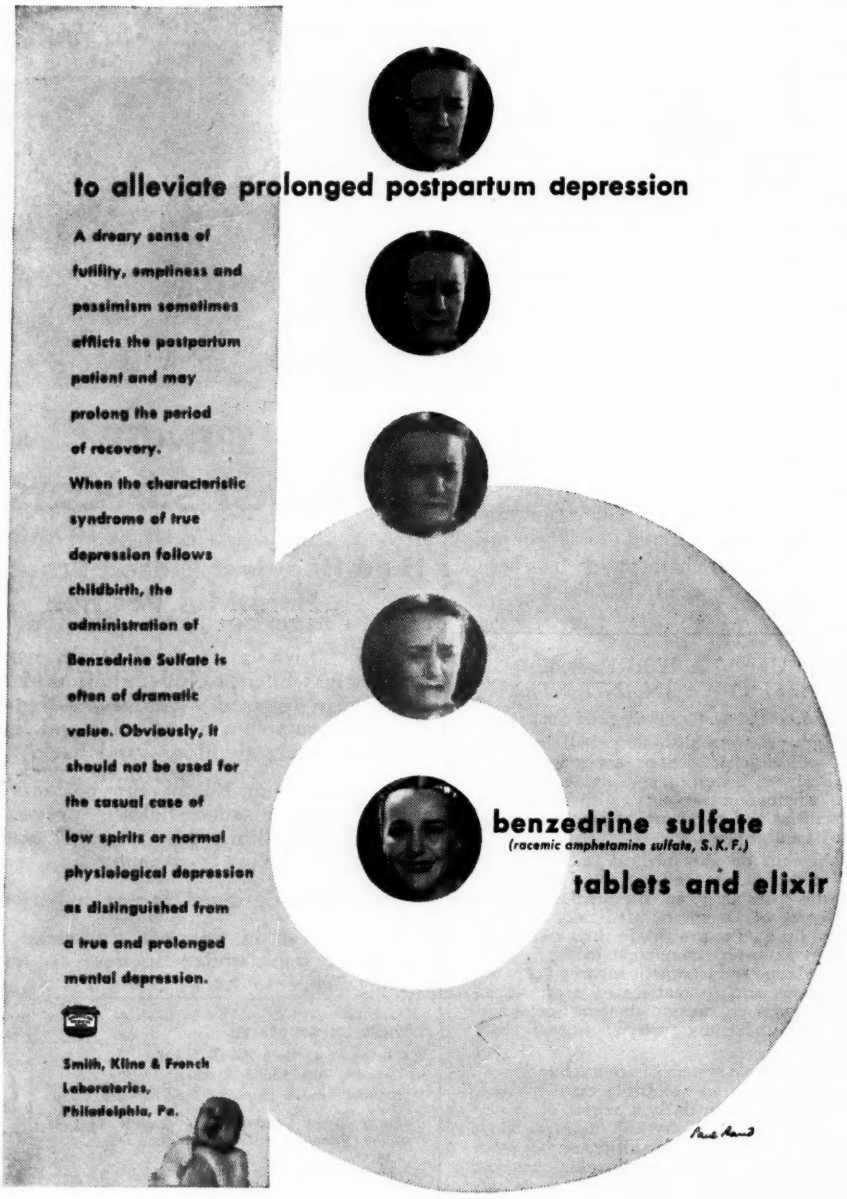
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A dreary sense of futility, emptiness and pessimism sometimes afflicts the postpartum patient and may prolong the period of recovery.
When the characteristic syndrome of true depression follows childbirth, the administration of Benzedrine Sulfate is often of dramatic value. Obviously, it should not be used for the casual case of low spirits or normal physiological depression as distinguished from a true and prolonged mental depression.
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RESIDENCIES AT BRADLEY HOME RESUMED

THE Emma Pendleton Bradley Home will again offer, early in 1946, opportunities for training in child psychiatry to physicians, psychologists and graduate nurses. The war has interrupted these programs during the past 3 years. Residencies of 6 months duration will again be offered to physicians qualified by previous residencies in pediatrics or psychiatry. Resident interneships in clinical psychology for a year will provide supervised training in clinical testing and psychotherapeutic guidance for psychologists with graduate school background. Three months' courses in the care of maladjusted children will be offered to graduate nurses.

The Bradley Home is still, after 15 years of operation, the only accredited and licensed independent children's psychiatric hospital in the United States. Originating under endowment funds created many years ago it serves a three-fold purpose consisting of clinical treatment for children with neurological and behavior problems, the training of professional personnel, and scientific investigation and research in its special field.

Post-war plans in several cities throughout the country call for the establishment of psychiatric hospitals and study homes for children. The Bradley Home has been deluged with visitors and inquiries seeking information as to the operation of such institutions. These indicate that the Home is recognized nationally, and that future hospitals will in many respects be patterned after features developed at the Bradley Home as the result of its years of practical experience in a relatively new field.

Although many Rhode Island physicians are familiar with the Bradley Home and have utilized its facilities there is still considerable uncertainty as to the status of this hospital in several Rhode Island communities. In the hope of dissipating through these columns some of this confusion the following frequently misunderstood features of this unique hospital are mentioned.

The Bradley Home offers psychiatric study and treatment, complete medical supervision, special schooling, sympathetic guidance in taking personal care of one's self and mingling successfully with others—all planned entirely for children who reside in the hospital. Parents are encouraged to accept regular guidance in learning to understand their children who are under treatment and planning their future care at home. *No outpatient service has as yet been established.*

Boys and girls under 12 years of age may be admitted if their intelligence is within normal limits, if they require special treatment, and if they and their families will presumably benefit from it. No children are accepted for temporary boarding or custodial care, on court order or other legal commitment, or for training of the type required for mental retarded ("subnormal", "feebleminded") children. Facilities for the treatment of children with cerebral palsy ("birth injuries", "spastic paralysis") have been discontinued.

All children must be directly referred by a practicing physician, and if residing within a reasonable distance, should come for preliminary examination at a weekly Saturday morning clinic, when financial arrangements are also made with parents. For Rhode Island children rates are arranged commensurate with family income. A number of hospitalization insurance policies are effective for care of children at the Bradley Home.

Physicians are welcome to attend clinical teaching staff conferences at the Bradley Home held weekly on Wednesdays at 11:30 A. M., at which time, through detailed case reports, the methods and results of in-patient psychiatric treatment for children are demonstrated.

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INDICATIONS: Local treatment of sulfonamide-susceptible infections of oropharyngeal areas; acute tonsillitis and pharyngitis; septic sore throat; infectious gingivitis and stomatitis; acute Vincent's disease.

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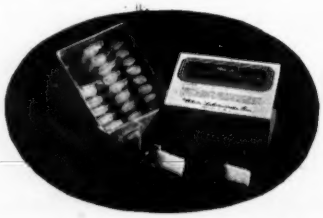

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TREATMENT OF INJURIES OF THE HAND

continued from page 891

and phalangeal fractures medullary wire may be inserted, but our experience with use of this wire has been limited to a few cases, and therefore our observations are not worth while.

When in the course of primary operative procedures conditions present do not permit approximation of divided bone or tendon or nerve, it is important to immobilize these structures: Bone with proper splinting and, if necessary, traction wire sutures. Tendon by use of fine wire or silk sutures in the proximal ends with the sutures brought through the overlying skin and tied under a little tuft of gauze. Nerve by insertion of an anchor suture of silk in the epineureum.

A little knot twice the size of the head of a pin is made in a piece of silk thread, the silk is threaded in a fine needle, and two such sutures are introduced a distance of 1 cm., or a little over, in a longitudinal direction on each side of the proximal end of the nerve. The suture is brought out through the epineureum 1/2 cm. proximal to the cut end of the nerve. It is then fastened to a suitable adjacent structure or brought out through the skin and tied over a little tuft of gauze. In cases in which there is considerable doubt as to blood supply and viability of muscle substance or overlying skin, after the wound has been cleansed and anchor sutures in retractable structures have been inserted, when primary skin grafting is not deemed advisable the wound is covered with fine mesh vaselined gauze. In about one-half of the cases, four or five narrow strips of rubber tissues are tucked into the wound, using the eye end of a long skin needle for this purpose.

Never is through and through drainage from one side of the hand to the other or from one lateral margin of a finger to the other, used. When drainage on both sides of a hand or of a finger is deemed necessary, it is best to insert that drainage from both sides rather than a single through and through piece of drainage material which must necessarily come in contact with and produce necrosis of or scarring about important intrinsic structures of the hand. A proper dressing is applied with use of machinist waste or sea water sponges incorporated in the dressing, so that even pressure may be maintained for control of oozing hemorrhage which is noted after removal of the tourniquet. Very rarely should a dressing be applied before releasing the tourniquet.

A splint of some kind is usually a necessity in these cases. It need not be an expensive splint. A number of important matters have been just touched upon in this discussion and have not been dealt with completely or even adequately. Here again no comprehensive description of various kinds of splints and the making of them is attempted. It is important to bear in mind that if a normal hand is placed on a flat straight angle splint and kept there with the palmar surface of the thumb down flat on the splint for two weeks or more, it would take three to four weeks to restore normal functions of the hand. Very frequently some form of cock-up splint should be used. These may be made out of wood or metal with relatively little expense and effort. A small splint for use in treatment of metacarpal fractures may be made by soaking two ordinary throat sticks in a basin of water ten or fifteen minutes. These throat sticks may then be bent into desirable position and held there with a piece of adhesive plaster applied as a string which holds taut two ends of a bow. Splints of lucite or some plastic preparation so treated that they, after soaking in water, may be molded are very serviceable.

In 75 per cent of the cases we see, no extensive operative treatment is undertaken as a primary procedure. Too great emphasis cannot be placed on proper cleansing of the wound; diagnosis of structures which have been injured; insertion of anchor sutures in order to prevent retraction of tendons and nerves; covering tendon with something, viable muscle, or perforated tinfoil, or vaselined gauze; a dressing carefully applied with even pressure on all parts of the wound, and resting the hand comfortably on a splint, are the things we try to do in the primary treatment of these lacerations of the wrist and hand. It may be many physicians would feel that discussion of local application of some sulfa drug preparation should be included in this address. Very rarely have we used any sulfa drug preparation locally. When now considered necessary in certain cases, these preparations are given by mouth or intravenously.

In the great majority of these cases with severe lacerations of the forearm and hand extensive constructive procedures are carried out as a secondary or elective form of treatment rather than a part of primary surgical treatment.

PENICILLIN TREATMENT OF EARLY SYPHILIS

continued from page 885

tion of Intravenous Drip Method to Chemotherapy as Illustrated by Massive Doses of Arsphenamine in Treatment of Early Syphilis, J.A.M.A. 104:878 (Mar. 16) 1935.

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[3] Moore, J. E., and others: Treatment of Early Syphilis with Penicillin, Preliminary Report of 1418 Cases, J.A.M.A. 126:67-73, Sept. 9, 1944.

[4] Bell, D. W. J., and Gregory, K. K.: Massive Arsenotherapy of Early Syphilis, R. I. Med. Journal 26:153 (Sept.) 1943.

BY INJECTION

subcutaneously or intramuscularly, ADRENALIN provides rapid symptomatic relief in asthmatic paroxysms; is useful in the prevention and treatment of other allergic reactions; localizes and prolongs the action of local anesthetics. Intravenously, it is used in shock and anesthesia accidents.

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BY INHALATION

orally, ADRENALIN relieves severe attacks of bronchial asthma by relaxing the bronchial muscles.

WELCOME HOME!

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably discharged or on terminal leave from the armed forces who had resumed private practice in the State as of December 1, 1945. Additional listings will be issued each month.

Barrington

MARDEN G. PLATT, M.D.....261 County Road; WA 0414

Bristol

SAMUEL D. CLARK, M.D.....366 Hope Street; Bristol 3

Cranston

L. ADDISON CURREN, M.D.....789 Park Avenue; WI 1568

East Providence

ERIC DENHOFF, M.D.....Bradley Home

Howard

GEORGE L. WADSWORTH, M.D.....State Hospital

Lafayette

AMEDEO MASTROBUONO, M.D.....Exeter School, Box 83

Pawtucket

LOUIS I. BEAUDOIN, M.D.....710 Main Street; BL 2019
EDWARD A. FOSTER, M.D.....569 Power Road; BL 2070
JOHN H. GORDON, M.D.....47 Cottage Street; PE 5280
EDWARD H. MCCAUGHEY, M.D., 50 McGregor Rd.; PE 7660

Providence

MICHAEL ARCIERO, M.D., 225 Admiral Avenue; GA 7330
RICHARD S. ARLEN, M.D.....359 Broad Street; PL 9618
ROBERT R. BALDRIDGE, M.D.....454 Angell Street; PL 2440
VINCENT A. BIANCHINI, M.D.,
1242 Cranston Street; WE 3198
KENNETH BURTON, M.D., 124 Waterman Street; GA 9413
E. ARTHUR CATULLO, M.D., 162 Academy Ave.; WE 6858
MORGAN CUTTS, M.D.....155 Thayer Street; DE 1341
JAMES FALLON, M.D.....Charles V. Chapin Hospital
DAVID FREEDMAN, M.D.....224 Thayer Street; DE 0042
F. CHARLES HANSON, M.D., 162 Angell Street; GA 9234
RICHARD HAVERLY, M.D.....841 Hope Street; GA 9825
WILLIAM N. HUGHES, M.D., 112 Waterman St.; GA 1431
FRANK C. JADOSZ, M.D.....2 Hawthorne Street; WI 1223
WALTER S. JONES, M.D.....165 Waterman Street; PL 7072
HUGH E. KIENE, M.D.....Charles V. Chapin Hospital
HERMAN A. LAWSON, M.D.....454 Angell Street; PL 2440
JAMES P. LONDERGAN, M.D.....81 Governor St.; GA 4255
HIMON MILLER, M.D.....105 Waterman Street; GA 2541
PARKER MILLS, M.D.,.....266 Smith Street; PL 6308
BENJAMIN S. SHARP, M.D.....339 Thayer Street; DE 0929
BRUCE W. SMITH, M.D.....203 Thayer Street; GA 2221
H. FREDERICK STEPHENS, M.D., 195 Thayer St.; GA 3867
GUY W. WELLS, M.D.....124 Waterman Street; GA 3111

West Warwick

PETER C. ERINAKES, M.D.,
119 Washington Street; Valley 0896-W

Wickford

GORDON E. MENZIES, M.D.,
154 West Main Street; Wickford 230

Woonsocket

SOLOMON L. FRUMSON, M.D.,
Monument Square; Woon 3293-J-2
GEORGE A. KEEGAN, M.D., 34 Hamlet Ave.; Woon 3400-W

ALL BUT 11,000 DOCTORS TO BE RELEASED BY NEXT JUNE

Army doctors are being released faster than the Army is reducing its total strength, in spite of the large number of battle casualties still remaining in hospitals and the requirement of doctors for separation center work, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently in New York in appreciation of the services rendered by member hospitals of the United Hospital Fund of New York.

"The peculiar situation that we find ourselves in is that demobilization, in which everyone is concerned, cannot proceed without the help of thousands of doctors—2,000 of whom are devoting their medical services solely to separation centers," General Kirk said. "By the first of January more than 14,000 doctors will have been returned to civilian life, which is more than one-third of the total number of doctors comprising the Army Medical Corps at its peak. By June of next year we anticipate releasing all but 11,000 doctors."

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INDUSTRIAL SAFETY IN RHODE ISLAND

G. CLIFFORD WORTHINGTON

The Author. *G. Clifford Worthington, of Pawtucket, R. I. President, Rhode Island Industrial Safety Association; Safety Director, J. & P. Coats (R. I.) Inc., Pawtucket.*

THE R. I. Industrial Safety Association, affiliated with the Providence Chamber of Commerce, was formed in 1943. Its membership originally included the graduates of the R. I. State College Industrial Safety Engineering courses which were sponsored by the U. S. Department of Education in coordination with the U. S. Department of Labor's National Committee for the Conservation of Manpower in War Industries. Graduates of the Safety Courses who are now members of the Association cover a good portion of industry in the state.

Membership eligibility since that time has been offered to any person whose livelihood is derived from daily accident prevention work in the industrial, mercantile, or commercial field; or any person who, by reason of his executive position in one of these fields, has an active interest or participation in furthering the cause of accident prevention. Today membership has increased to over one hundred and fifty representatives of approximately seventy-five of our state's various industrial plants.

Our object and purpose is the promotion of Industrial Safety in the State of Rhode Island.

Our activities are non-sectarian and non-political.

Our efforts are directed to work in harmony with the enforcement authority of the state and the national societies organized for the same fundamental objects. To this end we have been privileged to assist industry and the state in various ways. Most important, perhaps, has been in the formation of legislation necessary for the adoption of Safety Codes or Safety Standards. Many of our members have served on the various committees which have formulated the technical data written into the proposed Safety Codes. We feel that efforts directed towards this objective will help substantially to reduce, although indirectly, many industrial hazards which for years have taken a tremendous toll of man hours and lives from our productive machinery; hazards which have caused many serious injuries and, consequently, have brought about untold suffering, pain, and loss of income to industrial workers and exorbitant and needless cost to industry.

For a number of years the greater Providence area has had no organized Safety Program to offer to help industry in the promotion of Safety. It is true, of course, that many of the larger industrial plants in this area have carried out Safety Educational programs of their own during the past several years. However, most of their educational programs have been directed at the Supervisory level, and not too strongly, nor too effectively, to the man on the job, where education must reach to be of any substantial value. It is granted that Management and Supervision must first be sold on the value of such a program, but industry must go further in their educational work if they intend to reduce accidents. Most workers in the State do not work in large plants, and, therefore, have little or no safety education. Smaller plant Managements have not been fully sold on the value of accident prevention work and statistics prove that most accidents are caused in the smaller plants. Here is the place in which we hope to be of service.

In view of these conditions, we feel that the formation of such an organization or council, in the Greater Providence area, would assist industry by encouraging Management and worker to adopt more safe work habits and strive to eliminate machine hazards. We shall, therefore, cooperate with the National Safety Council and local organizations, in establishing such a program.

Most of our members are directly responsible for Safety in their own organizations. In this capacity they work closely with the Industrial Nurse and the physician. We need to create an organized plan that includes nurses and the physician which will enable us to lend a helping hand in conferences on safety problems. Everything which will bring about a clearer understanding of our common problems of safety will help all industry.

The Rhode Island Industrial Safety Association recognizes that the function of the industrial nurse is manifold. Upon her personality and professional skill depends the usefulness of the plant hospital or dispensary. Her work is strenuous and requires good health and almost unlimited energy.

In addition to the usual hospital training, the experienced industrial nurse requires a knowledge of

continued on page 911

"Denture Handicap"

A FREQUENT CAUSE OF NUTRITIONAL DEFICIENCY..

It has been observed* that "those losing their teeth frequently go through a period of adjustment to dentures when appetite slumps and subnutrition ensues." Neurotic or anxious individuals, with natively poor bites or narrow receding mandibles are most unhappy with "store teeth."

Often causing nervousness, indigestion and pain, dentures may thus seriously handicap nutrition. Particularly for those with difficulty in mastering new prosthetic appliances, the choice of foods is limited and the risk of malnutrition is ever present.

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* Tuohy, E. L.: In *Handbook of Nutrition*, A. M. A., Chicago, 1943, p. 380.

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WERNET'S POWDER

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continued from page 907

occupational health hazards. She needs the ability to advise on well-balanced diets for individual cases. She is often called upon to plan menus for the plant cafeteria. The nurse also makes recommendations regarding plant sanitation.

She is usually able to further the control and reporting of accidents by her detailed recording, not only of industrial accidents but by her reports on illnesses as well. In the case of the large plant, she is the direct contact between management, employees and the plant physician on industrial hygiene.

The nurse, on many occasions, is called upon to treat non-occupational problems and when necessary she refers them to a private physician. In some plants she is called upon to assist in determining the job best suited to the person under consideration. She provides through the management proper facilities for rest periods, especially in regard to women employees. In all cases she supervises the personal and plant hygiene facilities for women.

The industrial nurse who gains the confidence of both men and women workers is a valuable asset to the proper and efficient functioning of an Accident Prevention Program because of her more intimate knowledge of personalities and characteristics of the workers in a given plant.

We have called on the medical profession to discuss with us at our meetings many of the common perplexities we find in industry, and because of their helpfulness we will continue to call upon them and benefit from their long experience.

Workmen's Compensation is an important part of the Safety Engineer's work and many of our members have attended classes to better familiarize themselves with the provisions of our Workmen's Compensation Act.

We have served industry as consultants on various safety engineering problems and hope that industry will feel free to take advantage of this service in the future.

We are grateful for the active interest taken by the various members of the R. I. Dept. of Labor's Division of Industrial Inspection in our organization. Their experience in all phases of industry is of great value to us in our technical discussions.

Our organization is young. Much work is to be done to make our industries safe for the man on the job. We have studied accidents and their causes and we feel that we know some of the preventive measures that should be taken to make our industries safer.

We do not infer that most accidents are due to unsafe working conditions, for the facts prove otherwise. Unsafe acts and practices of the workingman or woman are the cause of a far greater number of accidents, and cause injuries equally as serious, as unguarded machines.

We believe that many safety programs have failed because insufficient attention has been given to the education of those involved in accidents; namely, the productive workers. Safety must be personalized to be effective. The state of mind of the individual worker is an important factor in accident prevention. Most safety programs have dealt mainly with Supervision, which is only proper in the initial stages of a safety program, but these programs have not followed through far enough down the production line to reach those who are involved in the greatest number of accidents.

On September 8, 1945, President Truman called upon the National Safety Council, and through them, to every citizen, in whatever capacity, to join in an accident prevention campaign and "by personal example, do his part to prevent the suffering, heartbreak, and tragedy that accidents bring." The R. I. Industrial Safety Association will do their utmost to assist in this program.

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PRIVINE

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Special Meeting held on November 15, 1945

A SPECIAL MEETING of the House of Delegates of the Rhode Island Medical Society was called by the President on November 15, 1945, at the Medical Library. The following officers and delegates were in attendance:

OFFICERS:
John F. Kenney, M.D., President
Herman C. Pitts, M.D., President-Elect
William P. Buffum, M.D., Secretary
Charles J. Ashworth, M.D., Treasurer
Peter P. Chase, M.D., Editor-in-Chief of the R.I.M.J.

KENT:
Rocco Abbate,M.D.

NEWPORT:
Samuel Adelson, M.D.
James C. Callahan, M.D.

PAWTUCKET:
Walter J. Dufresne, M.D.
Earl J. Mara, M.D.
Stanley Sprague, M.D.

PROVIDENCE:
Joseph L. Belliotti, M.D.
Alex. M. Burgess, M.D.
Bertram H. Buxton, M.D.
Edward S. Cameron, M.D.
G. Edward Crane, M.D.
Frank W. Dimmitt, M.D.
Edward V. Famiglietti, M.D.
Kalei K. Gregory, M.D.
Peter F. Harrington, M.D.
Frank I. Matteo, M.D.
Anthony V. Migliaccio, M.D.
Louis A. Sage, M.D.
Henry E. Utter, M.D.

WASHINGTON:
Juliana R. Tatum, M.D.

WOONSOCKET: None

The meeting was called to order by President John F. Kenney at 8:20 p. m.

The Secretary read a communication to the House from the Executive Committee of the Providence Medical Association asking for a discussion on the following resolution submitted to them by the Wayne County Medical Society (Michigan):

"Resolved that the House of Delegates of the American Medical Association take whatever action is proper at this time to create as soon as possible a new Section of General Practice to be duly constituted of equal rank and authority with the other sections already established and that the Delegates of the Michigan State Medical Society to the next American Medical Association Convention are hereby instructed to introduce this resolution to that body and that copies of this resolution be mailed to all American Medical Association Delegates."

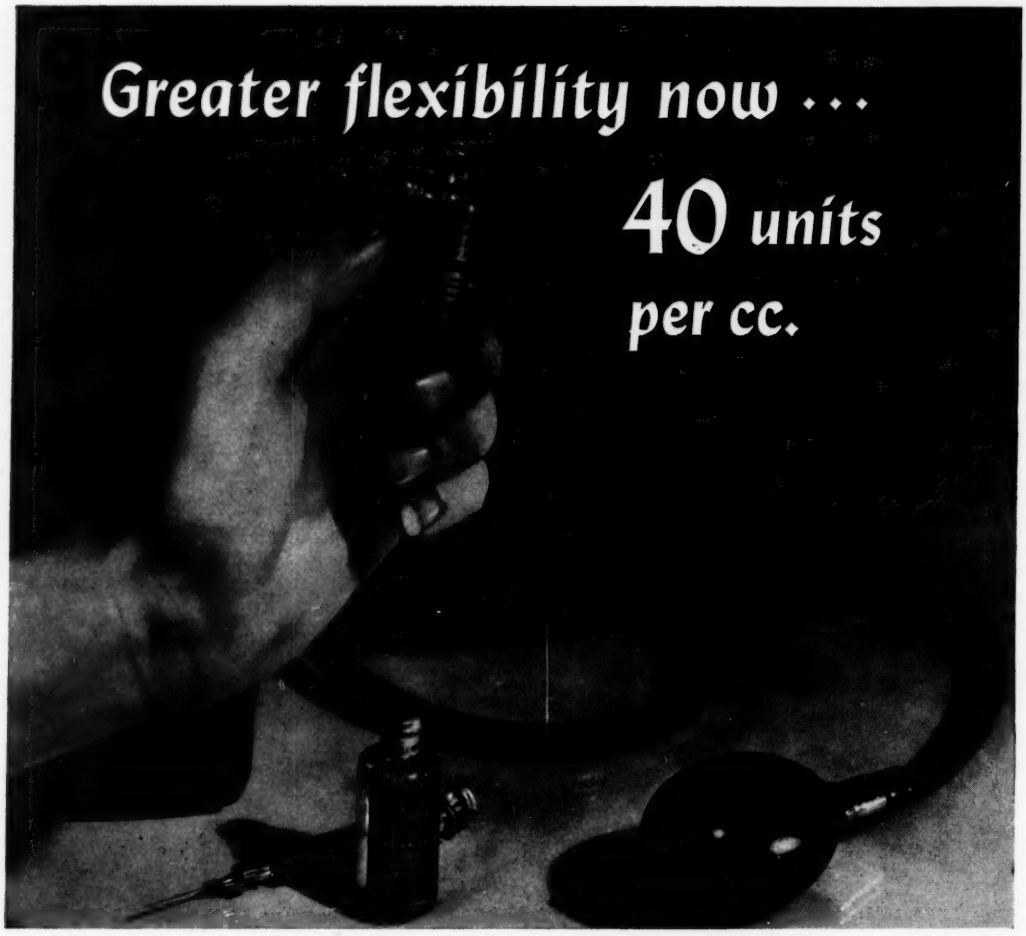
The proposal was discussed briefly by Dr. Henry E. Utter who moved that the House of Delegates instruct its delegate to the American Medical Association to express the approval of the Rhode Island Medical Society of this resolution if it is presented to the House of Delegates of the American Medical Association at its meeting December 3-6. The motion was seconded and unanimously adopted.

Dr. John F. Kenney reported that local physicians in private practice had been asked to conduct the physical examinations for recruits for the U. S. Army and several physicians had expressed a willingness to do the work. However, he reported that the First Service Command had established a fee of $2.00 for the first man in the group to be examined and $1.00 for each subsequent man. As this fee arrangement is at complete variance with established procedures under other programs as well as long established local fees, he asked for a special opinion from the House. Dr. Buxton moved that the House of Delegates of the Rhode Island Medical Society request that the Service Command Surgeon of the First Service Command be requested to notify the Army Recruiting Service that the Rhode Island Medical Society has gone on record that any physical examinations done by local physicians on recruits for the U. S. Armed Forces should be paid the minimum established fee prevailing in the locality in Rhode Island in which the examination is made. The motion was seconded and unanimously adopted.

Dr. Charles J. Ashworth, treasurer of the Society, submitted his report which had been approved by the Council for recommendation to the House of Delegates. This report included a proposed budget for the Society for the year 1946, which was presented in detail, and the proposal that the dues for each active member of the Society in 1946 shall be $25.00. It was moved by the House that the report of the treasure be accepted and that the dues for 1946 be set at $25.00 for each active member. The motion was unanimously adopted.

Dr. Alex. M. Burgess, chairman of the Committee on Post Graduate Education, submitted a revised report of his Committee on the plan for the

continued on page 917



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HOUSE OF DELEGATES REPORT

continued from page 915

local certification of specialists. He read the report and explained the reasons for the various procedures outlined. The proposal was discussed by the House. The opinion was expressed that there was a need for the listing of more specialists in Rhode Island than are already certified by the specialty boards. It was pointed out that the proposed certification program by the Society would provide for the older men who have not taken Board examinations and who would in the course of time probably be replaced by specialists certified by the various specialty boards. It was also pointed out that the plan could be carried forward as long as the Rhode Island Medical Society sees fit and its termination could be made at any time by the House of Delegates. The question was raised as to whether under the term of "general surgery" gynecological surgery would be included, and also whether orthopedic surgery would be included under "general surgery". The chairman of the Committee in answer to the latter question expressed the opinion that the various hospitals should be asked for a clarification of their procedures in listing their staff members for these specialties, and on the basis of such interpretations surgeons would be listed for both general surgery and gynecological and orthopedic surgery also depending upon their staff assignments.

At the conclusion of the discussion Dr. Henry E. Utter moved that the House of Delegates accept the revised plan as proposed by the Committee on Post Graduate Education for the local certification of specialists and that a list of specialists be drawn according to the provisions of the plan and submitted to the Society. The motion was seconded and adopted.

Dr. Herman C. Pitts, chairman of the Committee appointed by the House of Delegates to study prepaid voluntary surgical and medical insurance, read a final report from that Committee, a copy of which was submitted to each member of the House. In reviewing the problem Dr. Pitts pointed out that any scheme to be adopted must be considered as a form of public service to the community and must also be operated with due consideration of the fact that members of the Society engaged in the practice of medicine have limited time to devote to the supervision of a program.

In the light of the reports submitted Dr. Pitts posed the questions to the House to decide, first, whether a plan is needed and, secondly, what would be the best procedure to follow for its adoption.

The report of the Committee was discussed at length.

Dr. Kenney called for an opinion as to whether the House of Delegates does desire the formation and development of a surgical plan in Rhode Island. A motion was made by Dr. Alex. M. Burgess that the House of Delegates of the Rhode Island Medical Society go on record as desiring a voluntary medical care program operated on a prepayment basis. The motion was seconded and unanimously adopted.

Discussion then ensued as to the authority for establishing the policies for any such medical program as may be adopted.

Dr. Migliaccio moved that the House of Delegates go on record as favoring a voluntary medical program which would be related to the Hospital Service Corporation with each service having a separate corporation and a separate board of directors but a single executive director with one administrative staff, the medical plan to be administered by the Hospital Service Staff and the two plans being separate only in their policy making bodies. The motion was seconded and adopted with one dissenting vote.

Dr. Pitts asked for the discharge of the Committee which had made the report to the House of Delegates. It was moved that the House of Delegates thank and commend the special Committee for its work. The motion was seconded and adopted.

Dr. Migliaccio moved that the House of Delegates appoint the medical members of the special Committee previously appointed to study the medical insurance plan to confer with the Hospital Service Corporation relative to cooperation with the Medical Society in the development of a surgical insurance program. The motion was seconded and passed.

The President stated that Dr. Burgess, as delegate to the special meeting of the House of Delegates of the American Medical Association, desired instructions relative to several matters. Dr. Burgess stated that he would like to have the opinion of the House as to his vote on the Wagner Act and the Green Act now before Congress. Dr. Migliacco moved that the House of Delegates go on record as being opposed to both these legislative measures as now written. The motion was seconded and adopted.

The meeting adjourned at 10:30 p. m.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 5, 1945. The meeting was a joint one with the Rhode Island State Dental Society, and was called to order by President B. Earl Clarke at 8:45 p. m.

With the approval of the membership, the reading of the minutes of the previous meeting of the Association was submitted.

The Secretary reported for the Executive Committee as follows:

1. That a resolution from the Wayne County (Michigan) Medical Society relative to the formation of a General Practice Session in the American Medical Association be referred to the Rhode Island House of Delegates for discussion and possible action.

2. That the Association place paid advertisements once a month in the *Providence Journal* to publicize the return to civilian practice of members of the Association who have been in the service of the armed forces.

It was moved, seconded and passed that the report of the Executive Committee be accepted.

The Secretary reported that the Executive Committee recommended for election to active membership in the Association the following physicians: Dr. Robert Maiello, Dr. Bruce W. Smith, and Dr. Walter T. Zimdahl.

Dr. Henry E. Utter moved unanimous election of these physicians as members of the Providence Medical Association. The motion was seconded and passed.

The President extended a word of welcome in behalf of the Association to the several members present who have recently returned to the community after long service with the armed forces of the United States.

Dr. Clarke turned the meeting over to Dr. Gee, President of the Rhode Island State Dental Society, who stated that unless some member of his Society decided to introduce business for discussion, the meeting would continue with the scientific program. There being no business presented, Dr. Gee turned the meeting back to Dr. Clarke who proceeded to introduce Dr. Albert Midgley, former President of the Rhode Island State Dental Society, and present Chairman of the Committee on Dental Research, American College of Dentists, who spoke on "Medical and Dental Relations."

Dr. Albert L. Midgley reviewed the relationship between the medical and dental professions. He stated that the benefits which would result from perfect co-operation between the two professions have not been realized either locally or nationally. He suggested that a survey of the present situation and its shortcomings might well be made by a committee from the Rhode Island Medical Society and the Rhode Island Dental Society. The data assembled by such a survey should be used to improve the situation.

Dr. Clarke introduced Dr. Paul E. Boyle, Professor of Oral Pathology, School of Dentistry, University of Pennsylvania, who addressed the meeting on the subject, "Manifestations of Disease of the Mouth."

Dr. Paul E. Boyle presented a general discussion of pathological conditions found in the mouth. He viewed these diseases from the standpoint of the dentist, the physician, and the research worker.

He stated that the dictatorial manner in which some physicians demand that dentists remove certain teeth should be modified, leaving the final decision to the dentist after he has carefully examined the situation.

Numerous interesting slides were shown by Dr. Boyle, including one of the enamel rods as seen with the electronic microscope.

Dr. Boyle's presentation was briefly discussed from the floor by two members.

Dr. Clarke called attention to the recommendation made by Dr. Midgley in his presentation that the question of medical-dental relations in Rhode Island be studied by a committee of representatives from the Rhode Island State Dental Society, and the Providence Medical Association, and the Rhode Island Medical Society, and that this committee make a comprehensive study of all available data on the existing medical-dental relationship and of all available suggestions on what it should be, and then present its recommendation on how a medical-dental relationship that would be state wide in scope and content and most desirable in quality could be attained. Commenting on the excellence

continued on page 921

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 919

of the proposal, Dr. Clarke asked for an opinion from the members of the Providence Medical Association.

Dr. Anthony Corvese moved that the Providence Medical Association recommend to the Rhode Island Medical Society that it consider the recommendation made by Dr. Midgley. The motion was seconded and passed.

Dr. Clarke extended the invitation of the Providence Medical Association to the members of the Rhode Island State Dental Society to the collation to be served in the dining room after the meeting. The meeting adjourned at 10:45 p. m.

Collation was served.

Respectfully submitted,

FRANK W. DIMMITT, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The meeting was called to order at 9:00 p. m., October 23, 1945, with Dr. Alfred Tartaglino presiding.

The minutes of the previous meeting were read and approved.

New Business:

A motion was made by Dr. Adelson to incorporate into the records a resolution drawn up concerning the death of Dr. Douglas P. A. Jacoby. The motion was seconded and passed.

Application was received from Dr. Katz-Jerick asking for admittance to the County Society. Application was referred to the Board of Censors for investigation.

Due to the death of Dr. Jacoby, who was a censor, a vacancy existed. Motion was made by Dr. Adelson that Dr. MacLeod be made a censor. Motion was seconded and passed.

Dr. Zambarano of Wallum Lake was the speaker of the evening. He presented an interesting paper on "Procedures Used on Diagnosis of Chest Conditions." He stated that in chest diagnosis the symptoms are confusing inasmuch as all chest conditions usually had the same set of symptoms, that is, pain, dypnoea, rales, etc.

In diagnosis it is important to have a careful history and to make a physical examination. This is followed by X-ray of the chest which is the most essential part in diagnosing. This is followed by sputum examinations by first smear, then culture, then guinea pig; if no expectoration is present it is important that a gastric lavage be done. The washings are put through the same procedure as for sputum. This is then followed by bronchoscopy. Lipiodal is then injected to rule out bronchectasis. Chest tapping is only done once to determine the

continued on page 923

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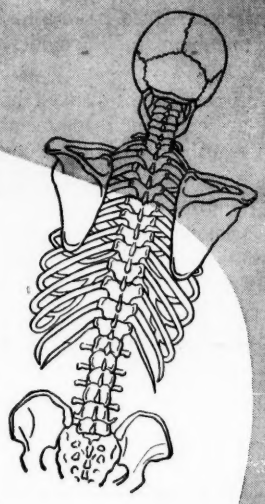
In Meningitis



IN the management of meningitis of pneumococcic, meningococcic, streptococcic, and staphylococcic origin, penicillin therapy presents advantages which in the minds of many observers* make it the treatment of choice, to be instituted in adequate dosage as soon as diagnosis is established. Because it is virtually nontoxic, penicillin may be given in effective amounts as long as required, intrathecally as well as systemically. Its therapeutic efficacy appears to be considerably greater than that of the sulfonamides, reducing mortality rates appreciably.

*McCune, W. S., and Evans, J. M.: Intraventricular Penicillin in the Treatment of Staphylococcic Meningitis, J. A. M. A. 125:705 (July 8) 1944.

Gould, A. H.: Mixed Bacterial Meningitis Following Cranio-Cerebral Trauma, Rocky Mountain M. J. 41:560 (Aug.) 1944.

MacNeal, W. J., and Pease, M. C.: Fulminant Meningococcemia Treated with Penicillin Calcium, Am. J. Dis. Child. 68:30 (July) 1944.

Rosenberg, D. H., and Arling, P. A.: Penicillin in the Treatment of Meningitis, J. A. M. A. 125:1011 (Aug. 12) 1944.

Sweet, L. K.; Dumoff-Stanley, E.; Dowling, H. F., and Lepper, M. H.: The Treatment of Pneumococcic Meningitis with Penicillin, J. A. M. A. 127:263 (Feb. 3) 1945.

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NEWPORT COUNTY MEDICAL SOCIETY

continued from page 921

type of pleural fluid. The reason that repeated taps are not done is to prevent possible infection in an otherwise sterile fluid. This is followed by sedimentation time and blood count. Chronic diseases of the chest are divided into tuberculosis, lung abscess, bronchectasis, cancer of the lung and foreign body. He then showed x-rays of many cases which were being treated at the Sanatorium.

The meeting adjourned at 10:30 p. m.

Collation was served.

PHILOMEN P. CIARLA, M.D., *Secretary*

AIR POLLUTION

At a forum on Civic Affairs held as part of the program sponsored by the Providence Chamber of Commerce on October 17 for a "Better Providence", the following recommendation on air pollution was adopted:

"First, we endorse the active work for correction of air pollution being carried on by the Public Service Engineer's department and urge continuous public cooperation.

Second, we advise an educational program by Mr. Mancini, Public Service Engineer, by articles on combustion to home owners through the press.

Third, we suggest that the Mayor appoint an Advisory Committee of not more than five to review the present smoke abatement ordinance and to consider if revision of the present ordinance or a new ordinance should be set up, and especially to consider the following changes:

1) **Inclusion of all classes of fuel-burning equipment,**

2) **Provision of authority to establish regulations on the installation and operation of equipment,**

3) **Provision for control of the emition of dust as well as smoke.**

It was further concluded that industrial and other consumers of solid and liquid fuels be urged to exercise close supervision of their present combustion equipment, and to install such available devices as will help reduce smoke and control fly-ash and other elements contributing to air pollution."

The above recommendation, approved by the Board of Directors of the Providence Chamber of Commerce following the "Better Providence Day" conference has resulted in the appointment by Mayor Dennis J. Roberts of an Advisory Committee on Smoke Abatement to consist of Professor Paul N. Kissler of Brown University, Dr. Edward S. Cameron, chairman of the Smoke Abatement Committee of the Providence Medical Association, Oresto DeSaia, Providence architect, Fletcher P. Burton, coal dealer, and Philip Mancini, public service engineer of the City.

RHODE ISLAND AUTOMOBILE DEALERS ASSOCIATION

Bulletin No. 12

162 Westminster St.
Providence 3, R. I.
November 19, 1945

DOCTORS RATE PRIORITY

Because of its logical appeal, we are reproducing in full a letter from John E. Farrell of the Rhode Island Medical Society. In this letter you will note that Mr. Farrell asks that dealers give preference to physicians returning from the service and desiring to re-establish themselves in business as well as preference to those who served so patiently on the home front during the war years.

The record of physicians in active service during the war require no panegyrics here. The official files of the War and Navy Departments testify in glowing terms to their courage and fearlessness in line of duty, but more significant than that is the marvelous record of recuperation of the sick and wounded servicemen under their treatment and observation.

As for the older doctors who stayed on the job, the long hours and the patient consideration they gave to all who needed attention are something that those of us who were compelled to call upon them will never forget. So when a doctor comes in the front door of your showroom give him the glad hand and the earliest and best deal you can. He rates it!

Mr. Farrell's letter follows:

"The Rhode Island Medical Society has noted that new automobiles are not to be rationed. We have also read with interest the press statement by Chester Bowles, Price Administrator, that he has urged automobile dealers to consider those who have pressing needs for automobiles when making sales.

In view of the fact that we have many physicians returning from the armed services who either have no automobile or one that needs to be replaced, we would like to ask that the Rhode Island Automobile Dealers' Association circularize its membership with this request from the Rhode Island Medical Society that every dealer give preference in so far as possible, first to physicians returning from service from the armed forces and re-establishing themselves in civilian practice in Rhode Island, and secondly to those physicians who have been carrying on the extra burden at home during the war years and who are in need of a new automobile.

We are sure that the essential use to which such automobiles will be put will warrant the consideration of this request by your membership, and we appreciate your cooperation in the matter."

* * * * * *

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LOCAL CERTIFICATION OF SPECIALISTS

(Revised Committee report approved by the House of Delegates at special meeting on November 15, 1945)

Prepared by the
COMMITTEE ON POSTGRADUATE EDUCATION

Alex M. Burgess, M.D., B. Earl Clarke, M.D., Harmon P. B. Jordan, M.D., Elihu S. Wing, M.D., and John F. Kenney, M.D.

YOUR committee drew up an elaborate plan for the setting up of local boards in the various specialties but abandoned this plan when it was pointed out that for the surgical specialties at least a national agency (The College of Surgeons) exists which has already classified a sufficient number of men in the surgical specialties to be adequate for the purposes involved. It was also pointed out that a plan of certification by boards of local physicians might easily lead to disputes and embarrassment. It was therefore decided to attempt to form a list of specialists, for the benefit of such agencies or individuals as might have a use for such a list, on the basis of classification by recognized national agencies and by the use of the listings on the staffs of hospitals. This would confine the listing to those who had acquired national certification of membership in specialty organizations, with the addition of older men who had achieved seniority of hospital staffs; and would not tend, by including them prematurely, to deter younger men from seeking national certification by specialty boards and membership in national societies. We therefore propose that a listing of specialists be compiled by the Rhode Island Medical Society Executive Secretary, to be given out to those who have a legitimate reason to ask for such a list, and that such a list be composed of physicians who belong to one or both of the following groups.

1. Those who have obtained certification by or membership in a nationally recognized board, college or similar organization pertaining to a recognized specialty. This would include all those certified by the national specialty boards, fellows and associates in the American Colleges of Surgery and Internal Medicine and similar organizations of like national recognition and scope.

2. Those who have attained the rank of visiting physician or surgeon on the staff of any of the hospitals listed below. By this is meant the highest grade in any department or service next to chief of service. This would include pathologists, roentgenologists and anesthetists who had attained senior rank though not necessarily heads of their departments. Their certification would in each case be only in the specialty in which the doctor holds his hospital position and not in any other field, even one closely allied (e.g., a general surgeon would not also qualify as a gynecologist.)

List of Hospitals

Rhode Island Hospital
Charles V. Chapin Hospital
St. Joseph's Hospital
Homeopathic Hospital
Miriam Hospital
Butler Hospital
State Hospital for Mental Diseases
State Infirmary
State Sanatorium, Wallum Lake
Pawtucket Memorial Hospital
Newport Hospital
Woonsocket Hospital
South County Hospital
Westerly Hospital

In case of doubt as to a physician's eligibility for listing as a specialist according to the above criteria, a decision shall be made by the Council of the Rhode Island Medical Society. The Council may also recommend for listing as specialists individual physicians who may have qualified themselves by holding positions which would entitle them to such listing in other states or in the public services.

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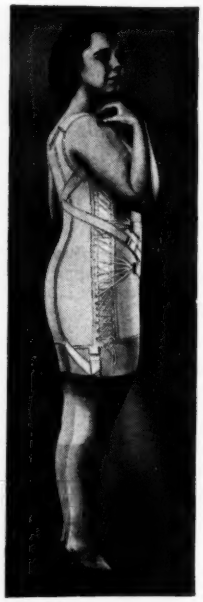

1 Their *basic construction* assures rest and protection to the spine . . .

2 They *may be reinforced* with pliable steels or the Camp spinal brace as desired by the Orthopedic Surgeon or Physician . . .

3 They are *easily removed* for treatment with other forms of physical therapy . . .

4 They are made of *varying height* to support the involved region or beyond as prescribed by the attending physician or surgeon.

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WEST WARWICK

Farrell, George B.
Tefft, Benjamin F.

WOONSOCKET

Medoff, Edward

* *With the Armed Forces*

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(December 1, 1945)

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*Case, Jarvis D.
*Chafee, Francis H.
*Conde, George F.
Cox, James H.
Donley, John E.
Dwyer, George J.
*Hoey, Waldo O.
Indeglia, Pasquale V.
Lenzner, Simon G.
Londergan, James P.
Mamos, Photius D.
Martin, Arthur E.
McGovern, Llewellyn
McLaughlin, W. H.
Milan, Michael B.
Palmer, William H.
Scorpio, Angelo
Tarro, Michael A.

CENTRAL FALLS

Sullivan, James F.

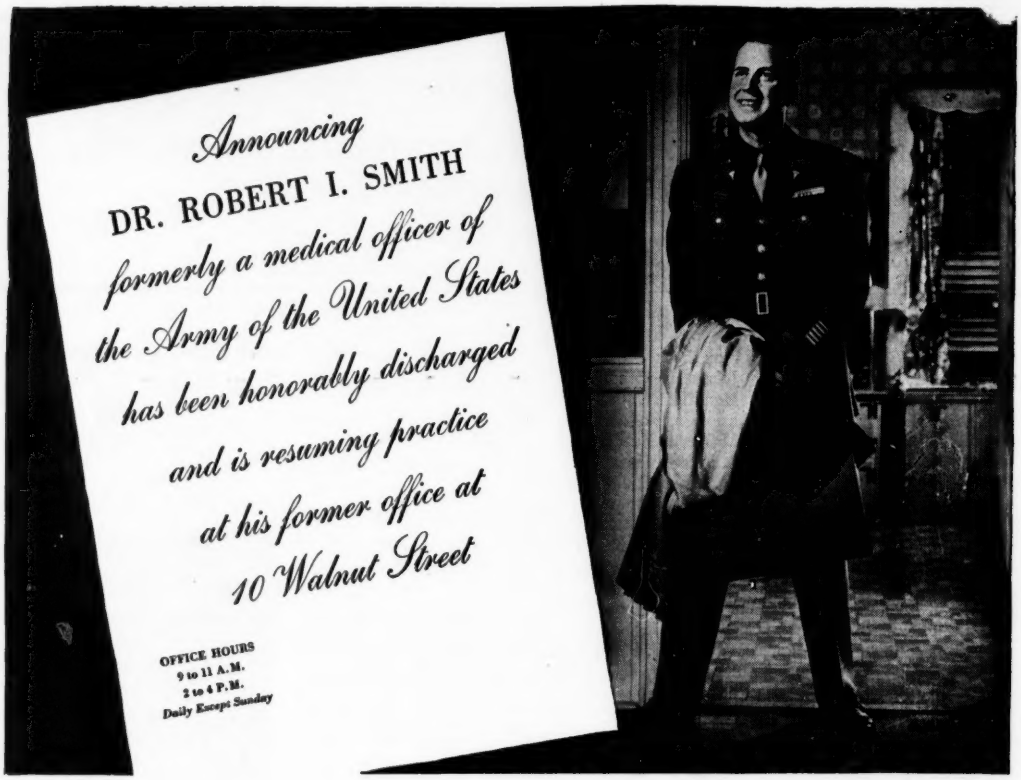
PAWTUCKET

Triedman, Harry

WOONSOCKET

Dupre, Guyon G.
King, Francis J.

* *With the Armed Forces*



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The medical men in the war will be the subject of novels, plays, and movies for years to come. But words, pictures . . . statistics, revealing as they are . . . won't begin to tell the whole story of the magnificent work you did. Nor will words be adequate to express fully the appreciation and thanks of your fellow men.

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WORKMEN'S COMPENSATION ACT. (As Amended)

Chapter 300, Article II

Section 5. The employer shall furnish reasonable medical, dental, and hospital services, and medicines when they are needed; provided, however, that the charge for medical and dental services and medicines, exclusive of hospital services, shall not exceed the sum of $300.00 in the case of an injured employee not receiving hospital treatment, or receiving hospital treatment for not more than 14 days, and shall not exceed the sum of $500.00 in the case of an employee receiving hospital treatment for more than 14 days; **provided, however, in unusual cases where the amounts stipulated by this section are not sufficient to cover specialized or prolonged treatment necessary to effect cure or rehabilitation of the injured employee, the Director of Labor may order payment of charges for medical and dental services and medicines beyond the stated maxima following hearing upon petition;* and provided, further, that the charge for hospital services shall not exceed $4.50 per day and such laboratory fees and such fees for X-rays and anaesthetics as are customarily charged by the hospital.

The employer shall install in a conspicuous place within the premises where the employees are working a printed notice that the employee shall have the right to select the physician or dentist by whom, and the hospital in which, he desires to be treated.

The employee shall have the right to select the physician or dentist by whom, and the hospital in which, he desires to be treated, and the employer shall become liable to such physician or dentist or hospital for the reasonable value of the services or treatment so rendered; provided, further, that the employer shall not become liable to the employee or to the physican, dentist or hospital for the services or treatment so rendered unless such physician, dentist or hospital shall give written notice to the employer within 7 days after the beginning of such services or treatment that he or they have been so selected, and shall, in writing, present his or their claim to the employer for the payment of such services or treatment within 3 months after the conclusion thereof. In case of any disagreement as to the amount of any charge for such medical, dental, surgical or hospital services, or for medicines, the reasonable value and amount thereof shall be determined by the Department of Labor. Said department shall assess costs in said proceedings.

The term "dental services" as used in this section shall be construed to include services rendered in making, repairing and replacing artificial teeth and dentures.

When an injury results in no disability or in disability of less than 3 days and the employer refuses or neglects to authorize medical treatment necessary for the repair or cure of physical or mental harm caused by the injury, the director may, upon his own motion or upon petition filed by an interested party, and after hearing as provided for in Article III of this chapter, order such medical treatment.

**The Director of Labor shall have authority to order a change of physician when in his judgment such change is desirable or necessary.*

In addition to all other compensation, the injured employee shall receive and the employer shall provide all medical, optical, dental and surgical appliances and apparatus of any nature, whatsoever, as may be reasonably required to cure and relieve from the effects of the injury, including but not being limited to the following: Ambulance and nursing service; eyeglasses; dentures; braces and supports; artificial limbs; crutches and other similar appliances. In the case of his neglect or refusal seasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

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THE MEDICAL SOCIETY AND THE WAR VETERAN

(A statement of the Bridgeport Plan by Joseph H. Howard, M.D., President of the Connecticut State Medical Society, to the Delegates of the Council of the New England Societies)

It would seem to me that one of the activities which is most important to our profession at the present time is the development of good will between the profession and the veterans. They are to be a very powerful factor in the American life in the next several years, and what we do for them will be reflected in their attitude toward the social changes which the politicians are now attempting to foster on the medical profession.

Veterans are returning in great numbers and are requiring examination and some types of treatment. If this is done in an indifferent manner, these restless and maladjusted boys will become disgruntled. Therefore, it is our job to plan a well-rounded method of handling these difficulties.

In Bridgeport we are fortunate in that there has been established a Community Advisory Service Center, financed by funds from the United War Fund. At this center any citizen or veteran may apply for advice in the fields of insurance, finance, home building, health, and various other fields. You have undoubtedly read about some of the activities of the Center since it has been publicized highly in newspapers and magazines. In the Community Center, the Veterans Administration has a section. Here, a full time physician has been assigned by the Veterans Administration for ordinary physical checkups. When a lot of these veterans present some complication which the medical examiner feels requires the attention of a specialist, these men are then referred to one of the doctors in Bridgeport specializing in that particular field.

We have felt that since this is a community problem, the work should be done by our local physicians and in our local hospitals, the object being to have the veteran better acquainted with the various medical men, and have him know his community hospital better. The disadvantage of examining these veterans in the basement of a school or in some hall, as was done by Selective Service, is that in case of X-ray, cardiography, or cystoscopy examinations, and various other special examinations, it would not be necessary to push the veteran from place to place to have a complete check made. The whole thing can be done under one roof.

We have in Bridgeport two large hospitals, Bridgeport Hospital, and St. Vincent's Hospital. The set-up is as follows: members of the Staff were canvassed to determine those willing to examine the veterans. This was necessary to make sure we had specialists in each particular field, and since these are large hospitals, we prefer to have two in each specialty since often one may be busy in the operating room, on vacation, or ill, and to prevent these boys from being delayed, we make certain that one of the examiners will be present at the appointed time. The Advisory Center notifies the hospital at least forty-eight hours beforehand as to the number of veterans to appear and the type of examination necessary. The hours selected for examination at one hospital are from eleven to twelve noon on Mondays, Wednesdays, and Fridays, and from eleven to twelve noon, Tuesdays, Thursdays, and Saturdays at the other hospital. In this way we have complete coverage six days a week. The veterans appear at the Advisory Center for the preliminary examination, and are then transported to the particular hospital examining that day. The staff and those necessary for the examination are ready to receive them. There must be no delay, and the work carried out promptly and efficiently. A Grey Lady is assigned to the waiting room to keep these boys occupied, and suitable reading matter is also there.

It is necessary in starting this procedure to begin slowly and so we have started the program by taking five veterans for each examination. The program is purely experimental. The Veterans Administration in Washington is watching it carefully to see if it "clicks". Some other method may be devised in other places, but we feel the proper place for this work is in the local hospitals.

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RENTAL CHARGES FOR DOCTORS' OFFICES

Office of Price Administration
Washington 25, D. C.
November 8, 1945

Mr. John E. Farrell, Executive Secretary
Rhode Island Medical Society
106 Francis Street
Providence 3, Rhode Island

Dear Mr. Farrell:

This will acknowledge your recent letter concerning the control of commercial rents.

As you know, the Emergency Price Control Act of 1942 was designed for the general purpose of combating inflation. The Act authorized the Price Administrator to control rents of housing accommodations in defense rental areas. As the war progressed it became apparent that rising commercial rents were causing hardships to persons engaged in business. In addition, such rises exerted an indirect pressure upon prices of cost of living items. For these reasons, I twice recommended to Congress that legislation be passed to bring commercial rents under Federal control. However, Congress has not seen fit to extend rent control to business accommodations.

I know you will be interested in the fact that just recently I appeared before the Senate Banking and Currency Committee and again pointed out our especial concern over the effect of rent increases of small businesses particularly retail and service trade establishments.

I appreciate your letter on this subject but regret that in the absence of Congressional authority we are unable to be of assistance along this line.

Sincerely,

(Signed) CHESTER BOWLES, *Administrator*

NOTE: *The above communication was in acknowledgment of a request from the Rhode Island Medical Society that the Office of Price Administration take some action relative to the control of rent of physicians' offices. This act was prompted by reason of the fact that some physicians returning from the armed forces are being charged high rents for office locations, particularly in residential areas.*

DR. WRIGHT JOINS BUTLER STAFF

Dr. David G. Wright has been appointed to the staff of Butler Hospital effective December 15th. Dr. Wright is to establish an Out-Patient Clinic and assist in teaching and clinical work. Dr. Wright is a native of Philadelphia, Pennsylvania; was graduated from Harvard College in 1934 and from the School of Medicine of the University of Pennsylvania in 1938; an interneship at Bryn Mawr Hospital in Greenmore, Pennsylvania and had a residency in psychiatry at the Department for Mental and Nervous Diseases of the Pennsylvania Hospital, followed by a year of research in Neurology under a Rockefeller Foundation Grant in New York, and a position on the staff of the Institute of the Pennsylvania Hospital before entering the Armed Services. During this time he was instructor in psychiatry at the University of Pennsylvania Medical School. During three years of military service attached to the Army Air Forces, he became Major MC, serving as field consultant in psychiatry for the 8th Air Force in England, as assistant chief of the Research Division and as assistant chief of the neuro-psychiatric section of the Air Surgeon's office in Washington, and later as chief of the neuropsychiatric services in the Army Air Forces Convalescent Hospital at Cochran Field, Georgia.

Dr. Wright is the co-author of "Psychiatric Experiences in the 8th Air Force" and is the author of "Notes on men and groups under the stress of combat" as well as several articles in the Air Surgeon's Bulletin relating to the psychiatric problems presented by combat flying and convalescence.

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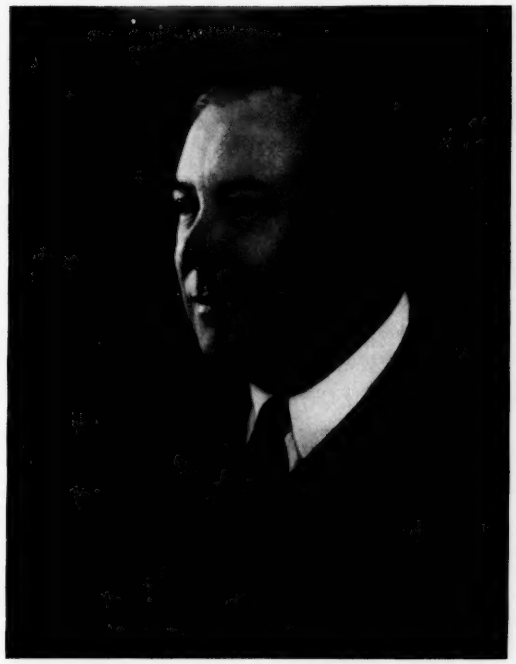
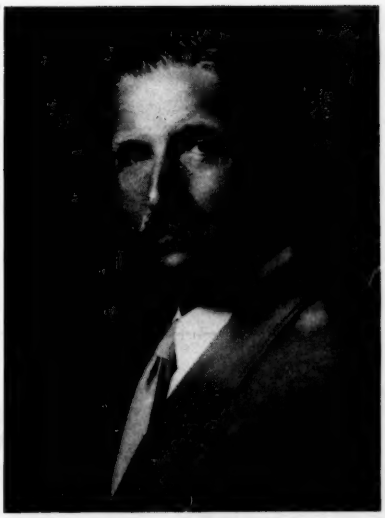


ROGER I. LEE, M.D.
of Boston

President, AMERICAN MEDICAL ASSOCIATION



JAMES R. MILLER, M.D.
of Hartford

Chairman, COUNCIL OF STATE MEDICAL SOCIETIES OF NEW ENGLAND; Recently elected as member of the Board of Trustees, American Medical Association.

INDEX OF ADVERTISERS

November, 1945, Issue of the Rhode Island Medical Journal

	PAGE
E. P. Anthony, Inc.	905
Ayerst, McKenna & Harrison	869
Blanding & Blanding	920
Borden Company	934
J. E. Brennan & Company	923
Bristol Laboratories, Inc.	935
Joseph Brown Company	933
Buffington's, Inc.	918
Burroughs Wellcome & Co.	Inside front cover, 916, 937
Charles Butterfield	899
Camel	930
S. H. Camp Company	928
Ciba Pharmaceutical Products, Inc.	Insert between 894-895, 912, 913
Coca-Cola	862
Commercial Solvents Corporation	922
Connecticut Mutual Life Insurance Co.	926
Crookes Laboratories	Inside front cover
Curran & Burton	905
The Doho Chemical Corporation	910
Edgewood Secretarial School	939
Industrial Trust Company	Inside back cover
H. W. Kinney & Sons	940
Lanteen Medical Laboratories, Inc.	936
Eli Lilly & Company	874 and insert between 874-875
S. E. Massengill Company	909
McCaffrey, Inc.	931
Mead Johnson & Company	Back cover
Medical Milk Commission	904
Merck & Company	871
A. B. Munroe Dairy	921
Narragansett Brewing Company	899
Nutrition Research Laboratories	872, 873, 906
Parke, Davis & Company	902, 903
Philip Morris & Company	868
Physicians Directory	943
Charles Raymond & Co.	863
Schenley Laboratories, Inc.	870
Schering Corporation	932
Schieffelin & Company	862
Smith-Holden Company	897
Smith, Kline & French Laboratories	866, 896, 924, 925
Spencer	895
E. R. Squibb & Son	938
Starkman Chemists	927
Frederick Stearns & Company	898, 914
Tilden-Thurber	911
Upjohn Company	894
Van Patten Pharmaceutical Company	861
Wernet Dental Mfg. Company	908
White Laboratories	864, 865, 892, 900
Winthrop Chemical Company	944
Wyeth, Inc.	Insert between 922-923
F. E. Young Company	942

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